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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

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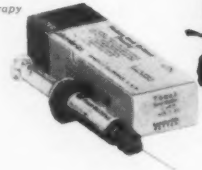

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Public Health Nursing in the National Emergency

WE AMERICANS have gone through a winter of great significance to the country and to ourselves as individuals. Looking backward to the momentous days, the beginning of the Korean incident, one is heartened by the good spirit, the desire to cooperate, evidenced by all. Our faith has never wavered that right and truth will prevail. At this writing the news from our fighting men is good. Our belief is strengthened that the forces of democracy are greater than the repressive might of fascism and communism.

But no matter how sanguine we may rightfully be, common sense tells us that our people must continue to live in a state of preparedness for possible grave emergencies until such time as the great nations reach a true understanding. It seems likely that for many years we must concern ourselves mainly with the plans and programs that will help our country remain strong and win through to a lasting peace.

We in the health field have an important role to play. We will do well to acknowledge now and plan ahead for a continuing period of an emergency nature—a period of shortages of personnel and equipment, of pressures and demands on programs—a picture already too familiar.

In this issue the NOPHN presents a statement on recommendations for agency adjustments to meet additional calls for service in the face of depleting staffs. Unfortunately, there is no magic formula. The realities of the situation can be met only by weighing needs and concentrating resources where they can accomplish the most for the families public health nurses serve.

The recommendations are based on practices which have been found to be effective where they have been applied. Almost all of them have been put to the test by alert, forward-thinking administrators in various parts of the country. They have proved themselves to be sound and good. It is not easy, especially in times of stress, to make drastic changes—yet it is the very stress that places the demands upon us—and nurses have never sought the easy way. It is incumbent upon everyone who has any sense of responsibility for public health nursing services to study the recommendations and see where some of these changes may be made almost immediately.

Every member of the staff, of the board, of committees, has an interest in these recommended adjustments—an interest in seeing that her community will have the best possible essential public health nursing services during the emergency period. Each one should have the opportunity to study the statement and present her thinking on it. Staff conferences and board meetings should be devoted to discussions and interpretation of the vital recommendations.

For some agencies applying the recommendations will mean greater changes than for others. If reassurance is needed, bear this in mind: The adjustments, although they pare certain services and definitely delimit or eliminate others, are based on sound principles of what is good for the community. When the time comes for broadening programs again it will be easier to build on the adjusted program, based on the healthy philosophy of fundamental services and proven technics.

The Relationship of Mental Hygiene to Growth and Development

MARCIA M. COOPER, Sc.D.

PRACTICALLY EVERY nurse nowadays accepts as a matter of course the fact that human growth and development normally follow an orderly pattern or sequence of steps. We are familiar with the landmarks of physical growth in infancy and childhood. But we sometimes lose sight of the emotional development which accompanies it, as well as the fact that all advances in development involve change of some sort—change in size and change in function. Such changes require readjustment on the part of the individual and those around him in the form of new activities, new attitudes, and new relationships.

This pattern of development is not finished when the adolescent reaches adult size and function but continues until life's end and provides many of the fields of endeavor which occupy the public health nurse. That is to say, the adolescent girl rapidly becomes an adult who experiences marriage, motherhood, and the menopause. Her counterpart establishes himself in a job, and both encounter the responsibilities, anxieties, and satisfactions involved in setting up a home, rearing children, and striving for security. This pattern is complicated for nearly all by occasional illness, accidents, and the eventual departure of the children from the home. Finally, there is retirement and old age, with the necessity for new adjustments in the way of living and very often accompanied by dependency and chronic illness.

At every point in this cycle the public health nurse can and does play an important role. In order to do so with as much satisfaction as possible to herself, her patient, and the community she should appreciate what a particular experience means to the patient as an individual and to the group of which he is a member. She should interpret each to the other when necessary. For it is only when each stage of development is accomplished with all possible strength and satisfaction that it forms a firm, wholesome foundation upon which succeeding stages may be safely built.

For instance, a mother with her first baby may feel that an exact feeding schedule makes for efficiency in planning her own work and is good training for her baby. The nurse may help her to recognize what a fundamental threat it is to her hungry infant to have to wait for half an hour and, conversely, what a satisfaction self-demand feeding would be to him until he is old enough to settle down to regular feeding habits. In regard to the older baby who has arrived at the toddling, into-everything stage, she can explain his normal urge to learn through exploring handling, mouthing, et cetera. She and the mother can then work out together safe, simple ways of providing constructive, satisfying activities and play materials for the child. The great advantage, however, will be

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the improved relationship between mother and child on the basis of which both go forward to the next stage of development.

Feeding is perhaps the most important single experience of the infant and young child, for it not only provides the material for his physical growth but is closely linked to his emotional development and has important cultural and family associations which are likely to persist throughout life. With this in mind the nurse can guide the mother in making feeding a satisfying experience which both share, rather than one of anxiety and frustration for one or both of them.

Some infants should be permitted to have an irregular, self-demand schedule for the first few weeks. Although some mothers can accept and carry out such a schedule easily others will need help from the nurse to understand how to do so with confidence. Some babies are slow to accept new experiences comfortably and this may first be observed when solid foods are introduced. In such cases the inexperienced, conscientious mother, anxious to follow the doctor's directions, may force the new food in spite of the child's protests. This method may appear to be successful for a time but the child's growing resistance to the feeding situation in general becomes a real problem later when he has developed more ability to express his own ideas.

It is more desirable to allow such a child to accustom himself very gradually to the new food, offering it only in such amounts as he will accept readily, no matter how small, or even waiting for a week or two when he may be ready to accept it more willingly. It is also well to recognize that every child does not have to eat every kind of food. Most adults have their preferences and dislikes, and a child is entitled to a few dislikes too. These need cause no anxiety since a sufficiently varied diet insures that another food will provide the nutritional values of the one which is refused.

THE URGE TOWARD independence may be seen very early in some children. Mothers of such youngsters report that at about one year they become determined to feed themselves but are still too clumsy to do so except with their fingers—and the mess they make! One worried mother complained that her ten-month old son had refused to take anything but his bottle for the past three days. When the feeding situation was observed it was discovered that this mother who was always rather overneat was, at this time, in the first trimester of pregnancy and suffering a good deal of nausea. She found her baby's efforts to feed himself quite revolting to watch and so had resorted to holding his hands behind his back with her left hand while forcibly spooning the food into his mouth with her right. His protests had become more and more determined until finally he had reached the point of turning his head away from the advancing spoon and refusing solids altogether. There was much to be said in favor of both mother and child, but a compromise worked for both when the mother saw the importance of it. When protected by a large plastic bib and left alone with the food before him the child fed himself with great satisfaction and his mother didn't have to watch.

Another problem situation which is inherent in the growth situation arises from the fact that the rate of growth begins to slow markedly after the first year and by two years has almost reached a standstill. Because of this the child's appetite may decrease considerably some time in the second year. When the baffled mother contrasts this smaller appetite with the ravenous one he had as a baby she may feel that the child is either sick or "ornery" and begins a determined struggle to increase his intake. Unfortunately, this tug of war often occurs at the time the child is normally entering the negativistic period of development, and each factor reinforces the other in building friction between mother and child. This situation could be avoided if the mother were forewarned that such behavior is a normal phase of development, observed in most children to some extent. She can then let the child be the judge of how much he wants to eat, secure in the knowledge that under ordinary circumstances he will eat enough for his growth requirements if left alone to do so.

One of the most important achievements

for any child is to become independent. Most parents give this idea lip service at least. Many parents have a genuine desire to have the child reach this goal but feel that it will come automatically at some future time—when he is eighteen perhaps, or when he gets his first job, or marries. Meanwhile they take it for granted that his every decision and activity shall be dictated to him by the much wiser and more experienced adults in his life. And why not? They love him and know what is good for him. They want him to grow up strong and well, escape injury, be well mannered and dressed neatly and suitably, to progress in school—in short to be a success in his own small way and do the family credit. Is there anything wrong with that? Yes, there is something fundamentally wrong. The child who becomes accustomed to wait for some adult to tell him what he should do eventually finds himself in a situation in which he must think for himself and make his own decision. Then, since he is totally unused to think and act on his own initiative he becomes panicky. If the pressure becomes too great he may develop psychosomatic symptoms, or limp through life in his own particular psychoneurotic pattern, for psychological handicaps can be more crippling than physical injuries.

THE WISE MOTHER will recognize as steps toward achieving independence and self-confidence such things as her baby's demand to feed himself at one year, his interest in taking off and putting on his shoes, sweater, et cetera, at two years, the school child's increasing demands for freedom of activity, and the adolescent's interest in the opposite sex. Although these and similar ventures may cause his parent momentary anxiety or irritation they are all evidences of growth and as such should be the source of just as much satisfaction as his steady weight gain was in infancy. Often, however, such new steps require parental encouragement and guidance in order that they may be satisfying to the child and acceptable to his family. It is in this respect that the nurse may help the mother in understanding and practical management.

During childhood these changes come rapidly one after another and we hardly have time to get used to the preschooler who is content to remain close to home than we are faced with the school child who must negotiate traffic on his way to school, make his own way with many strange children and adults, and who is demanding a bicycle, an allowance, and a later bedtime. In adult life the changes occur much less frequently, but all of us make new ventures, new relationships, and new adjustments in which the nurse may be called upon to help.

The mother experiencing her first pregnancy may be a "prenatal" to some nurses, but in addition she may be a rather bewildered and even resentful young girl who feels that she hasn't yet had a chance to become sure of her adjustment to marriage. She may be doubtful of her ability to take on this new responsibility and fearful of the experience itself. The nurse who is interested in her as a person as well as a case may be able to resolve some of these unnecessary fears, or by merely listening sympathetically help the mother accept the situation more comfortably. One young Negro mother in telling of her first delivery laughed ruefully as she said, "Oh, I gave those nurses and doctors a hard time. I took on terrible. You see, I spent most of the time while I was pregnant with my big sister in the South and she kept telling me that death walks around the bed of a woman in childbirth ninety-nine times and, if you haven't fetched your baby by that time, the hundredth time he gets you! It seemed so long and I kept wondering how many times he had been around and I thought he would get me sure!" This superstition may have had some reasonable relation to the maternal mortality rates for Negro patients in the rural South, but this mother found herself at delivery in a large, modern hospital under expert medical supervision. It is quite possible that her fear and tension prolonged her labor. Certainly she made it a much more frightening experience than it need have been.

UNDER PRESENT CONDITIONS a chronically ill patient must often be cared for at home. This problem is not just one of giving

nursing care or teaching someone in the household to do so. The patient must give up accustomed activity and the status of one who makes his contribution to family life. Each member of the family carries an extra burden or feels some deprivation. Resentment and anxiety grow on both sides. One mother bringing her children into the well baby clinic confided, "My children give me no trouble; it's my invalid mother-in-law. Because she has to be with us we don't have proper sleeping space for the children. I never can go out because she gets so upset if she's left alone. She speaks only Polish and I don't know any Polish. Sometimes I think I'll go crazy." It would be easy to sympathize with either of these unfortunate women—one sick, dependent, unable even to talk to the resentful daughter-in-law who cared for her, the other resentful of the time and the space she had to give this alien woman at her children's expense. When the situation was viewed as a problem for the whole family some plans were worked out that relieved the tension for all to some extent. With some help the old lady was gotten up in a chair for part of each day. She was then encouraged to do a little mending, prepare vegetables and help in other ways. The older children formed the habit of taking their after-school snack into her room and sharing it with her. At such times she taught them little Polish songs, et cetera. She was again making some contribution to family life. The children regarded her with more affection and respect and their mother had a little more freedom.

Many nurses feel that to be aware of problems means that they must then deal with them, and the prospect is staggering. But this doesn't necessarily follow. Recognition of problems sometimes means only that the nurse does her usual job with more effectiveness. Other problems are outside her province, but she usually has a much better knowledge of the community's resources than the family and can refer them to the appropriate professional source of help.

There will always be some individuals who do not respond to the most well meant and helpful suggestions. In such cases the nurse should feel that she has done what she could and the rest is the responsibility of the patient or his family. If she attempts to go further she may begin to resent what seems like indifference or resistance on the part of the patient while he in turn may resent what he feels as undue pressure. The result is that both may work at cross purposes and both may feel guilty—the nurse because she hasn't succeeded in carrying out what she knows to be important in the patient's medical care, and the patient because he has not done what is expected of him.

It is better, once the need and the available resources are clear to the patient and the nurse has made her interest felt in a friendly way, for her to let the patient work the problem through for himself. The result may not be what the nurse would have planned but it may be equally practical and more acceptable to the patient, if only because it is his *own* solution. To do otherwise may create a situation in which the nurse by her genuine interest and efficiency makes her patients overdependent upon her and so makes a mistake similar to that of the overprotective mother.

Some time ago a Negro mother with quite a flock of children was observed to be very casual in her clinic attendance. She came when she thought she needed to and otherwise stayed away. We felt that we were "not making a dent in her." One day she surprised us by coming in without an appointment to tell of a perfectly appalling tangle of problems that had arisen due to the sudden death of her husband from pneumonia. When she was through we asked her what she wished us to do and she answered, "You can't do anything, but I was so mixed up I felt if I could talk it over with a friend it would come clear in my mind what *I* have to do." This incident taught us a highly valued lesson. This mother had profited much more than we realized from the clinic relationship but it was not measured in clinic attendance. She remained an independent person, able and willing to cope with her own problems.

What then does all this mean to the public health nurse as she goes about her day's work? It means that by viewing the whole

(Continued on page 304)

Our Magazine—
a Major Tool in Professional Education

ELEANOR PALMQUIST, R.N.

THAT A PROFESSION needs a magazine as a means of widespread communication would, I believe, be accepted without question. It follows then that this magazine would be of value in the educational program of that profession. The objectives of our introductory course in public health nursing are:

To explore the scope and function of the nurse in the community.

To learn the structure within which the nurse functions in the community.

To develop an understanding of the evolution of nursing in the community, current problems, and trends.

To develop an understanding of the principles basic to effective functioning of the nurse in the community.

To study the relationship of the nurse in the community to the private physician and other community workers.

How PUBLIC HEALTH NURSING may be used as an educational tool in promoting the above objectives will be briefly presented here.

The magazine is of value for study of both current and historic issues and developments. The content of issues of the last five years is generally considered current. For historic interest copies of the magazine and the bulletins which preceded it are available back to 1909. Students are encouraged to subscribe to the magazine since it is used in place of a textbook. The NOPHN offers special reduced rates to students subscribing in a group. This facilitates matters for the class.

Public health nursing is a part, but not the whole, of an amazingly large number of areas in addition to nursing and public health. As well as all of the service areas, from pediatrics to geriatrics, there are those that filter through the whole, such as nutrition, mental hygiene, and dental hygiene. In addition, there are areas from which public health nursing borrows and to which it contributes, such as education, counseling and guidance, social work, and health education. The fact that PUBLIC HEALTH NURSING synthesizes current information from all of these areas has long been accepted by public health nurses as the one hope of keeping informed. The student quickly becomes aware that she will not learn all she would like and should know about public health nursing during the time she is in school. Familiarity with the professional magazine and an increasing ability to use it are reassuring as an available means of continued growth.

Reports of events of national and international interest as well as publications and activities of official and voluntary agencies are a potential means for keeping informed or for learning where additional information may be secured. The scope of the magazine contributes a feeling of professional togetherness. Nurses in the North, South, East, and West, as reflected in the pages of the magazine, seem to share the same ideals and meet many of the same problems. The interest of

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the nonnurse citizen, the sociologist, the research worker, the psychologist, and many others, as shown through contributions to the magazine, reflects the value of the public health nurse in the community. This is of importance to the student who must develop a sense of belonging and a conviction regarding the value of her work.

At each class session a student may report on any recent article. This has a threefold purpose. It motivates the students to browse through the magazine, gives them the opportunity to choose articles of special interest, and provides experience in leading a discussion. A more important value is the fact that the discussion of the article inevitably brings out differing opinions and thus stimulates thinking. Perhaps this effort to encourage individual thinking is what one student had in mind when she said that she had not realized she would be expected to do "creative studying." In order that class discussions may be purposeful they are summarized by formulating principles of public health nursing. The principles developed by each class, although fundamentally the same, vary as they are developed from the experience and reading of the students as reflected in the discussion.

In considering the history of public health nursing, back issues of the magazine provide an opportunity for the students to see developments through the eyes of the leaders of earlier times. Students are asked to browse through the bound volumes prior to 1920. The following are samples of articles in the 1915 volume:

Fulmer, Harriet. The pioneers in public health nursing. *The Public Health Nurse Quarterly*, January 1915, v. 7, p. 19-22.

Waterman, Richard. Efficiency in public health nursing. *The Public Health Nurse Quarterly*, April 1915, v. 7, p. 71-85.

Beard, Mary. Prenatal nursing. *The Public Health Nurse Quarterly*, July 1915, v. 7, p. 13-24.

Gardner, L. Mary. President's address, third annual meeting of the National Organization for Public Health Nursing. *The Public Health Nurse Quarterly*, October 1915, v. 7, p. 29-33.

Wile, Ira S. The nurse of tomorrow. *The Public Health Nurse Quarterly*, October 1915, v. 7, p. 46-54.

BROWSING THROUGH the older volumes has incidental values. The emphasis on typhoid fever, description of the sanitation nurse, as well as information on such topics as how to clean a stove, helps students to get a feeling for problems of public health nursing in the early days. Any tendency to become complacent vanishes when our "modern" developments, such as geriatrics, mental hygiene, and hospitals as health centers, are found mentioned in the magazines prior to 1920.

The humor and conviction of the nurses, as reflected in the pages of these issues, make an enjoyable and worthwhile contribution to discussions on the development of public health nursing.

Articles about the student's home state have particular appeal. Two of the many articles on state programs that may be used are:

Smith, John A. State programs of public health nursing. *The Public Health Nurse*, September 1920, v. 12, p. 730-743.

McIver, Pearl. Public health nursing legislation. *The Public Health Nurse*, July 1930, v. 22, p. 372-376.

The series of articles by James A. Tobey on "State Laws on Public Health Nursing," referred to by Miss McIver in the above article, serve as a means of stimulating interest in present laws.

Other articles of historical interest that should not be overlooked are:

Dock, Lavinia L. History of public health nursing. *The Public Health Nurse*, October 1922, v. 14, p. 522-526, and November 1922, p. 590-593.

Beard, Mary. Public health nursing and its administration; municipal and private control. *The Public Health Nurse Quarterly*, April 1917, v. 9, p. 147-155.

Emerson, Haven. The visiting nurse, a county service. *The Public Health Nurse*, July 1923, v. 7, p. 345-353.

The nurse in the county health unit. PUBLIC HEALTH NURSING, January 1932, v. 24, p. 7-12.

Drinker, Cecil K. Problems and progress in public health. PUBLIC HEALTH NURSING, January 1936, v. 28, p. 10-14.

Winslow, C.-E. A. Nursing and the community. PUBLIC HEALTH NURSING, April 1938, v. 30, p. 230-237.

Sumner, Mary R. When we were very young. PUBLIC HEALTH NURSING, July 1941, v. 33, p. 422-3.

Little time is spent on history as such, because the main objective is to follow developmental patterns, thereby learning how public health nursing "got that way." To accomplish this the articles on specialized versus generalized nursing service are followed through the magazines of January 1916, April and October 1922, the issues of 1931 and 1932, on through "Desirable Organization of Public Health Nursing for Family Service" in August 1946, and Katharine Faville's discussion, "Organizing the Community for Public Health Nursing," in February 1947. Discussion of these articles presents opportunity to explore reasons for the opinions expressed, how they developed, and what their present counterparts are. The span of time covered by these articles helps point up the time required to effect changes in community practice.

The place of bedside care in public health nursing is studied in the same way. The following references are given to the student as leads:

Fox, Elizabeth G. Is a visiting nurse a public health nurse? *The Public Health Nurse,* August 1919, v. 11, p. 575-578.

Lent, Mary E. The fundamental importance of bedside care in public health nursing. *The Public Health Nurse,* September 1920, v. 12, p. 774-781.

Wald, Lillian G. The public health nurse as an educator. *The Public Health Nurse,* February 1921, v. 13, p. 74.

Fraser, Mary G. Setting to work as a county nurse. *The Public Health Nurse,* August 1921, v. 13, p. 412-416.

Champion, Merrill. Again, what of the public health nurse? *The Public Health Nurse,* February 1923, v. 15, p. 67-69.

Foley, Edna L. Bedside care. *The Public Health Nurse,* May 1923, v. 15, p. 235-240.

Royer, Franklin. Public health nursing versus bedside work. *The Public Health Nurse,* May 1923, v. 15, p. 231-234.

Kass, Marie. Are we going back to bedside nursing? PUBLIC HEALTH NURSING, October 1941, v. 33, p. 588, 590-593.

Vickers, Kathryn. Bedside nursing is part of our job. PUBLIC HEALTH NURSING, October 1941, v. 33, p. 589-590.

Prindiville, Marguerite. Joint voluntary and official programs. PUBLIC HEALTH NURSING, February 1941, v. 33, p. 96-101.

To follow this subject up to the present time, "Desirable Organization of Public Health Nursing for Family Service," August 1946, is pertinent. "Health Officers Adopt Public Health Nursing Principles," January 1947, climaxes the series. No student must read all of these articles, but if the reading is divided among the class members the content of all the articles contributes to the class.

The relationship of the public health nurse and social worker is followed in the magazine from Mary Gardner's article in April 1917 to Katharine Hardwick's "Trail Blazing in Social Work," *The Public Health Nurse,* March 1930, v. 22, p. 115-121, and finally to Cora Kasius' article, "Public Health Nursing and Family Case Work," PUBLIC HEALTH NURSING, October 1938, v. 30, p. 590-595.

Had we achieved in practice what was advocated by Miss Gardner in 1917, this article would still be of historic interest. However, it has even greater value in that it presents a philosophy and pattern that we are still trying to attain in 1951. The "why" is an inevitable part of the discussion.

It is interesting to compare recent articles on citizen participation with "A Discussion of the Characteristic Values and Limitations of Lay Members on a Professional Directorate" by Mary Beard and Alice A. Wood in the August and September 1921 issues. Twenty-five years have made many changes in personnel policies and in the functions of the public health nurse. Progress is made evident by comparing "Policies and Problems of Public Health Nursing Services" in the 1925 issues with current personnel policies and with "Public Health Nursing Responsibilities in a Community Health Program," February 1949.

When this approach is used the students' thinking seems to follow the same developmental stages through which public health nursing has passed.

PUBLIC HEALTH NURSING is the only tool by which a complete chronological approach can be developed. It is invaluable to the student while she is in school and continues so for the rest of her professional life.

Inservice Education in Cancer Nursing

ROSALIE I. PETERSON, R.N.
GENEVIEVE R. SOLLER, R.N.
MARGARET F. KNAPP, R.N.

EVERY NURSE wants to help a patient who is suffering. Whether the illness is cancer, tuberculosis, or heart disease is immaterial. The patient needs help and the nurse wants to give it. Her effectiveness, however, depends upon her knowledge of the disease, her understanding of the patient, and her ability to give skilled nursing care and to teach the patient and his family.

Agencies responsible for nursing service who wish to provide maximum support to the cancer program and adequate care to the cancer patient must give thought to the preparation of the nurse. It is impossible for any one nurse to master everything that should be known in the complex array of specialized fields of knowledge. In cancer, probably as much as in any other field, knowledge and technics are rapidly expanding and constantly changing. If the nurse is to be kept up to date, and her knowledge and practice brought into close balance, there must be continuous inservice training.

Cancer inservice education programs, like any others, should be designed to meet the needs and interests of the individual and the group. The educational director or supervisor responsible for educational programs should have a high degree of alertness, anticipate needs, and provide opportunities for the nurse to recognize and meet her own inadequacies or limitations. No nurse should be allowed to get on strange or unfamiliar ground before she is ready. High dividends are paid when the nurse is well prepared for she will find cancer challenging and will grasp every opportunity for effective teaching in a real situation.

There is no single method of conducting inservice education and no blueprint which will guarantee a comprehensive, effective program. Each community and nursing agency has its own peculiar problems and needs which should form the basis of a functional program. A good approach is "problem solving" which involves the following steps:

1. Analyzing, defining, and stating the problem
2. Determining the nurse action that should be taken
3. Deciding what the nurse should know in order to take the action
4. Determining the methods or procedures to be used in developing the necessary skills or abilities
5. Evaluating the selected learning and total outcomes.

During the next few months a series of articles will appear in PUBLIC HEALTH NURSING presenting an outline on cancer nursing using a "problem-solving" approach. This outline will include seven areas or units of work. A real problem substituted for the hypothetical one may be more tangible and meaningful to the nurse. The development of the inservice staff program should reflect the philosophy of the agency and should be based upon the specific needs of the learner.

The cancer inservice education program should be an experience in living and working together. The educational director has four major responsibilities:

First, to see that the administrator's ap-

Miss Peterson is chief, Mrs. Soller, assistant chief, and Miss Knapp, formerly assistant chief, Nursing Section, National Cancer Institute, Public Health Service, FSA.

proval is secured and that time is allowed in the nurse's day for study, observation, and practice.

Second, to secure the cooperation and participation of the private physician, detection center, tumor clinic, hospital, health department, and other agencies providing service to the cancer patient. Each agency should understand the objectives of the educational program for nurses and the role that it is to play. When intramural or extramural participation is desired, time must be allowed for planning and interpretation so that each will receive maximum benefits from the experience. For example, if the tumor clinic doctor is asked to interpret to the nurses the services of the clinic he should at the same time be helped to see that casefinding and caseholding will be improved in direct proportion to nurses' understanding.

Third, to provide source materials for the use of the nurse. No single textbook should be used but instead a variety of current periodicals, pamphlets, and the like. An extensive list of source materials, visual aids, and other teaching devices has been developed by the Cancer Nursing Section, National Cancer Institute, and is available upon request.

Fourth, the educational director and staff should cooperatively determine the objectives and outline the program.

The user of this outline should feel free to use all or parts of it and in any order desired. It may be expanded or limited depending upon the interests and needs of the individual and group, the resources available, and the amount of time allowed for inservice education.

Suggested Outline: Cancer Nursing Inservice Education

I. CANCER—A PUBLIC HEALTH PROBLEM

Statement of Problem

In a community of 10,000 persons it is estimated that in any one given year there will be:

35 newly diagnosed cases of cancer
12 cases diagnosed in a previous year but still under treatment
Of these two categories 14 will die of cancer, and,
17 additional persons will have undiscovered cancer.*

It is believed "that if present diagnostic and curative services of the finest type were available to everyone, two thirds of the people who develop cancer could be cured. Today we are curing only one third."**

1. How much cancer do we have in our community?
2. What are we doing to control cancer?
3. How effective is our cancer control program?
4. What improvements are needed?
5. What is my role in cancer control?

Content

A. The cancer problem
   1. Statistical
      a. Mortality (local, state, national)
      b. Morbidity (local, state, national)
   2. Sociological aspects
   3. Psychological aspects
      a. Patient
      b. Family
      c. Professional
      d. Lay

B. Cancer control program
   1. Education
   2. Early discovery
   3. Prompt, adequate treatment
   4. Follow-up
   5. Rehabilitation

* These data are based on experience in morbidity surveys in five metropolitan areas: Atlanta, New Orleans, Denver, San Francisco, and Pittsburgh. The surveys were conducted by the National Cancer Institute in 1948.

** Unpublished speech given by Dr. Austin V. Deibert, chief, Cancer Control Branch, National Cancer Institute, at Harvard Medical School, Boston, November 7, 1948.

6. Research
7. Evaluation
8. Legislation

C. Functions of the nurse in cancer control
1. Casefinding
2. Caseholding
3. Rehabilitation
4. Education
5. Research

Suggested Activities

1. Make a simple study of your community to determine (a) mortality (b) morbidity (c) population characteristics, such as occupations, economics, health practices (d) resources available (e) housing.
2. Analyze a cancer patient record for physical, emotional, social, economic, and related problems.
3. Appraise and discuss attitudes toward cancer.
4. Review your state and local cancer control programs.
5. Plan a cancer control program for your community.
6. Discuss the adequacy of cancer legislation in your state.
7. Discuss the values of cancer reporting and case registers.
8. List the functions of the nurse in the cancer program.
9. Discuss methods of integrating cancer in the generalized program.

BIBLIOGRAPHY

Bliss, Muriel F., and Randle, Bosse B. Cancer in a public health nursing program. PUBLIC HEALTH NURSING, August 1941, v. 33, 474-476.

American Cancer Society. Cancer death rates for each state in the United States by sites. N. Y., American Cancer Society, 1949.

New tools for professional cancer education. Cancer Reports Section. *Public Health Reports*, June 17, 1949, v. 64, p. 769-776.

Cutler, Sidney J. The role of morbidity reporting and case registers in cancer control. *Public Health Reports*, August 25, 1950, v. 65, p. 1084-1089.

Cherkasky, Martin. Hospital service goes home. *The Modern Hospital*, May 1947, v. 68, p. 47-49.

Deibert, Austin V. Recent developments in cancer control. *American Journal of Public Health and the Nation's Health*, February 1948; v. 38, p. 191-201.

Dorn, Harold F. Illness from cancer in the United States. *Public Health Reports*, January 14, 1944, v. 59, p. 33-48; January 21, 1944, v. 59, p. 65-77; January 28, 1944, v. 59, p. 97-115.

Dorn, Harold F. Chronic disease—the use of statistics in cancer control program. *American Journal of Public Health and the Nation's Health*, May 1949, v. 39, 602-606.

Ferguson, Marion. Public health nurse and the cancer control program. PUBLIC HEALTH NURSING, July 1948, v. 40, p. 343-346.

Hueper, W. C. A methodology for environmental and occupational cancer surveys. Public Health Technical Monograph No. 1. 1950. U. S. Government Printing Office, Washington 25, D. C.

Kaiser, Raymond F. Proposed elements of a state cancer control program. *Public Health Reports*, September 16, 1949, v. 64, p. 1169-1181.

Knapp, Margaret. Cancer nursing, a manual for public health nurses. Raleigh, N. C., Health Publications Institute, Inc., 1950.

Kress, Louis C. The nurse's part in the control of cancer. PUBLIC HEALTH NURSING, February 1939, v. 31, p. 85-89; March 1939, v. 31, p. 170-173; April 1939, v. 31, p. 229-233.

Public Health Service, Federal Security Agency. Cancer services and facilities in the United States. Public Health Service Publication No. 14. Washington, D. C., PHS, FSA, 1950.

McKee, Dorothea. Visiting nurse society and cancer patient. PUBLIC HEALTH NURSING, April 1946, v. 38, p. 155-157.

National Cancer Institute. National Cancer Institute Act. 1938. U. S. Government Printing Office, Washington 25, D. C.

Peterson, Rosalie I. Public health nursing in the cancer control program of the U. S. Public Health Service. *American Journal of Public Health and the Nation's Health*, February 1948, v. 38, p. 206-210.

Phillips, Elisabeth C. Chronic illness and the nurse. PUBLIC HEALTH NURSING, February 1947, v. 39, p. 87-91.

Program of the National Cancer Institute. *Public Health Reports*, April 16, 1948, v. 63, p. 501-517.

II. THE NATURE OF CANCER

Statement of Problem

The science teacher from the local high school has asked the public health nurse to assist in the development of a unit of study related to cell growth. He is especially desirous that cancer be included.

What does the nurse need to know in order to give this assistance?

Content

A. Normal cell and cancer cell growth and degeneration
B. Predisposing causes of cancer
C. Early symptoms
D. Types of cancer

1. Carcinoma
2. Sarcoma
3. Lymphomas (leukemia and Hodgkin's disease)

E. Distribution
1. Age
2. Sex
3. Site

F. Methods of spread

G. Effects of cancer upon the body

Suggested Activities

1. Have a pathologist or other qualified medical person discuss nature of cancer.
2. Show and discuss films:
   a. *What is Cancer?*
   b. *Challenge: Science against Cancer.*
3. Attend tumor conference. Note primary and metastatic cancers.
4. Review hospital case histories and list early symptoms and observable physical effects.
5. See gross specimens in pathology laboratory.
6. Observe necropsy for metastatic spread.

BIBLIOGRAPHY

Ackerman, Lauren V., and del Regato, Juan. *Cancer; Diagnosis, Treatment and Prognosis.* St. Louis, Mosby, 1947.

American Cancer Society. *A Cancer Source Book for Nurses.* N. Y., American Cancer Society, 1950.

A Teaching Guide to the Challenge of Cancer, Washington, D. C., Federal Security Agency, Public Health Service, National Cancer Institute, 1950.

Grant, Lester. *The Challenge of Cancer.* Washington, D. C., Federal Security Agency, Public Health Service, National Institutes of Health, 1950.

Moore, Robert A. *Textbook of Pathology,* Philadelphia, Saunders, 1944.

Westchester Cancer Committee of the American Cancer Society, Inc. Youth looks at cancer. Bronxville, N. Y., 1950.

FILMS

What is Cancer? Nursing Series. 16 mm. Color. Sound. Available through state divisions, American Cancer Society, or state health department library.

Challenge: Science against Cancer. 16 mm. Sound. Available through state divisions, American Cancer Society.

Sections III and IV of this outline—Cancer Discovery and Diagnosis and Treatment of Cancer—will appear in our June issue.

Eyes That See Not

THE LITTLE blind old lady with the placid features and the fringe of curly gray hair has met a great many new nurses in the past few months. You see, we've merged our services—the Public Health Nursing Service of the San Mateo County Department of Public Health and Welfare and the Visiting Nursing Association of San Mateo County, Incorporated. The little blind old lady lives alone and over the years has learned to know all the visiting nurses who, when their turn came for weekends on duty, visited her to give her her daily hypodermic of insulin.

But now the weekend on-duty lists have three times as many nurses on them. And the little blind old lady is learning to know the county nurses as well, as one by one they take their turns of weekends on duty.

We don't have much money for new equipment, so in our combined program each nurse uses the bag that her own organization made available to her. What if the county bags are a little smaller, we asked ourselves—what does it matter, except that we have to pack them a little more carefully in order to get everything in.

Our little blind old lady surprised us last week, though, when she asked us this question. "Are you," she wanted to know, "are you a *little*-bag-nurse or are you a *big*-bag-nurse?"

Emily Stringfield
Redwood City, California

Recommended Adjustments for Public Health Nursing Services in the National Security Program

Two statements on nursing in the national security program appeared in the February 1951 *issue of* PUBLIC HEALTH NURSING: *"Mobilization of Nurses for National Security" and "Public Health Nursing in the National Security Program." This is the third of the series. It has been prepared under the direction of a special* NOPHN *committee whose members include representatives of voluntary and governmental agencies in different parts of the United States, persons in various kinds of positions within those agencies, and both nurses and nonnurses. The statement is intended as a guide for public health nursing services in making necessary adjustments.*

DURING THE TENSE and troubled times ahead, agencies that provide public health nursing services have the responsibility of reviewing their programs and procedures in the light of changing conditions. Much that has been considered desirable up to now may have to be put aside if there is stepped-up mobilization. Even if there is no fullscale war but only a long period of defensive preparedness, many adjustments will be necessary.

The necessity for adjusting to change is not new to agencies providing nursing services. To some extent they have always had to be flexible in plans and program. In the near future, however, decisions may have to be made within a framework of conditions unlike any faced before. Questions and problems may seem familiar, but, because of a new set of circumstances, some of the answers may have to be completely different.

For example, if there is stepped-up mobilization, which services should have priority? Can any be discontinued? How can communities be sure that major overall needs, rather than only segments of needs, are taken care of first? What shortcuts can be effected in agency procedures? How can nonnurse personnel, paid and volunteer, help? What is more, how can that help be made as effective as possible? If necessary, how should public health nurses be redistributed within a community, area, or possibly the whole nation?

Priority of services

If mobilization increases and the nurse supply continues to be less than the demand, agencies will need to decide which services are most essential to the health of the community and which can be cut to a minimum or discontinued.

This decision for any one community will be influenced to some extent by local factors.

Some geographical areas, for instance, have a high incidence of certain diseases and other health problems. In some places midwives deliver many of the babies. But because these are peculiarly local problems, no further reference will be made to them in this statement.

There will always be cases when individual circumstances—especially social and emotional problems—must be taken into consideration. For example, an agency, as suggested here, may adopt a policy that public health nurses will not make home visits to normal maternity patients under the care of a private physician. But in spite of this general policy, the agency will undoubtedly give service to a normal maternity patient who is alone in a strange community and whose husband is in military service. She may need help more than does a patient with complications who is under good medical care and has an interested family to care for her.

In general, the recommendations concerning priorities for public health nursing services in this statement are based on five assumptions:

1. As mobilization is stepped up, adequate rest, good nutrition, and mental hygiene will be of increasing importance to the well-being of the people. Therefore, public health nurses will pay increasing attention to these aspects in all their work with individuals and families.

2. People who are able to be up and about will be urged to receive treatment in groups, as in clinics.

3. Patients will receive as much treatment and instruction as possible while they are at a hospital or public health clinic.

4. Public health nurses will not spend their time on activities that can be carried out by other persons. Some of these activities are: visiting homes to give clinic appointments or to urge patients to attend clinics, transporting patients, making a routine inspection of school children, doing audiometer and vision testing in schools, taking heights and weights.

5. If this country is ever hit by enemy bombings, special emergency measures will, without question, have precedence over any of the services mentioned in this statement. Since civil defense authorities are planning and will direct civil emergency measures, these are not included in this statement of priorities.

Recognizing that some local factors must be taken into consideration and that exceptions may have to be made according to individual circumstances, the committee recommends that the following services be considered essential and given priority, but not necessarily in this order:

1. Service to persons with specific communicable diseases, including tuberculosis and infectious syphilis, in conformity with state laws and state and local sanitary codes.

Priorities for public health nursing services in the control of communicable diseases would, of course, conform to the rules or regulations established by state laws and local ordinances. However, it is essential that these be revised if necessary so they will be in line with current knowledge.[1] Priorities should be based on the prevention and control of the communicable diseases for which public health nursing is most effective, such as diphtheria, infectious syphilis, smallpox, tuberculosis, typhoid, whooping cough. Public health nursing care of patients with poliomyelitis is also essential. Increased emphasis on known immunization measures is especially important in view of what might happen if this country were ever struck by enemy action.

In general, all tuberculosis patients and families who may endanger their own and other people's health need the services of the public health nurse. Patients' needs will depend, in part, on the frequency of medical supervision and their ability to care for themselves and to carry out measures to protect others.

Each agency needs a policy or guide for selecting patients and families for supervision. The policy for tuberculosis patients should be based on the recommendations of the tuberculosis control division of the state or local health department. The guide should classify types of cases on a priority basis according

[1] American Public Health Association. *Control of Communicable Diseases in Man.* 7th ed. N. Y., Macmillan, 1950. Anderson, Gaylord, and Arnstein, Margaret. *Communicable Disease Control.* 2nd ed. N. Y., Macmillan, 1948.

to their infectiousness. For example, patients who have active pulmonary tuberculosis with positive sputum within the past twelve months need more frequent and closer nursing supervision than patients who have pulmonary tuberculosis with negative sputum. In general, only those persons known to have been intimately exposed to tuberculosis within the past two years and not under medical supervision—especially infants, very young children, and young adults—should be given public health nursing services.[2]

2. Care of newborn infants and maternity patients who have complicated conditions, or who are delivered at home, or discharged unusually early from the hospital.

Maternity patients who have certain complications, such as toxemia, syphilis, cardiac disease, or who have had previous miscarriages, will continue to need careful supervision in their homes between visits to their physician or clinic.

Priority should be given to home visits to newborn infants in the following categories: prematures, that is, babies with a birth weight of five and a half pounds or less; babies with severe birth injuries or congenital malformations for which immediate measures could be instituted; babies delivered by midwives; immature infants and those with feeding problems; babies born out of wedlock if there is a special problem involved; and those born of syphilitic mothers.

Mothers delivered at home or discharged unusually early from the hospital who do not have a family to help them should be high on the priority list. Many mothers with firstborn babies also need care. In a time of extreme shortage of nursepower, however, it may be necessary to suspend visits to them unless they are in the categories mentioned above.

3. Bedside nursing care to persons acutely sick in their homes, including those who are suffering an acute episode in longtime illness or who are receiving a new treatment.

The drain on hospitals will undoubtedly become as severe, or possibly even more severe, than during World War II. Hospitals may send patients home while they still need bedside nursing care. If personnel shortages become critical, it may even be impossible for some acutely ill persons to be admitted to hospitals—especially in areas where a shortage of hospital beds already exists. The demand for parttime bedside nursing care to people in their homes may accordingly increase to such a point that it will have to be rationed with more than usual concern for priorities.

Such care to people in their homes will be of two types—that given by practical nurses under public health nurses' supervision and that given directly by public health nurses, that is, the professional nurses employed by the public health agency. All agencies need policies that state in which types and stages of sickness direct public health nursing care should be given and in which practical nursing care may safely be given. Medical advisory committees should review and approve these policies, keeping in mind the competing demands for public health nurses' time.

4. Assistance with mass education of civilians in home nursing technics and preventive measures that may help them to keep well and to take care of themselves if there is a national emergency.

Helping families to help themselves as much as possible in time of sickness has always been an integral part of public health nursing. In the future this will be of increasing importance to minimize the drain on medical and nursing resources, to bolster civilian morale, to help keep those working in important defense plants on the job, and even to help save lives.

To spread this type of service among a

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[2] Mikol, Edward X. A guide for the clinic and nursing supervision of tuberculosis cases and contacts. Unpublished. Dr. Mikol is general director of tuberculosis hospitals, Division of Tuberculosis Control, New York State Department of Health, Albany, N. Y.

South, Jean. *Tuberculosis Handbook for Public Health Nurses.* National Tuberculosis Association, 1950. Pages 41-44.

maximum number of persons, group instruction should be substituted whenever possible for work with individuals. It can be given in such services as maternity, child care, home nursing and care of the sick, and in such conditions as diabetes and heart disease. Group education can also be directed to those responsible for the care of children in day care centers or foster homes, to industrial workers, to school staffs, and to parents of school children.

It is recommended that public health nursing services try to find new ways of providing group instruction and demonstration so they will reach more persons than could be assembled in office or school. Because television is a potentially powerful mass educational medium, public health nursing agencies in areas with video facilities might investigate its possibilities. These may be somewhat limited because of restrictions on subject matter and because a skill usually cannot be acquired by observation alone. However, certain aspects of subjects might be "opened up" on television or radio, then followed up through group work.

Inactive public health nurses who may be unable to work full time because of family responsibilities may, after orientation and under supervision, be able to teach groups as volunteers. It is important that their help be enlisted whenever possible.

In all types of classes public health nurses should spend their time teaching only that which is within their sphere and competence, or which others could not teach so well. Very often public health nurses and other professional workers might collaborate in teaching groups.

5. Orthopedic service to those persons who will benefit most, especially younger persons for whom rehabilitation and improvement are a good possibility.

In deciding which patients should have orthopedic service, priority should be given to those who can benefit most and for whose rehabilitation the family will assume its share of responsibility. Medical recommendations, ability of the patient and his family to carry out treatment as demonstrated by the orthopedic nurse or physical therapist, accessibility of available qualified personnel, the patient's diagnosis and prognosis—all are factors to be taken into consideration when determining the frequency and length of service to orthopedic patients.

For example, all patients with complicated fractures, peripheral nerve injuries, or poliomyelitis should receive intensive treatment. Length of treatment for maximum recovery may vary from two to three months for a patient with a simple fracture to twelve to eighteen months for a poliomyelitis patient. Generally, the family should be able to assume responsibility under the supervision of a nurse and the physical therapist (or the physical therapist alone) for carrying on treatment of patients requiring a long rehabilitation program, such as the hemiplegic, the cerebral palsied, and the arthritic.

Where physical therapists are employed, it is advisable for their services to be given in conjunction with that of public health nurses. Physical therapists should be considered as consultants to generalized public health nurses.

6. Service in clinics.

Since major emphasis in time of national emergency must, of necessity, be on mass technics and group service, public health nursing in clinics will have high priority. However, public health nurses' time in clinics should be used to the best advantage and only for those activities that require public health nursing preparation, experience, and judgment. It is recommended that public health nurses in clinics have only the following responsibilities:

a. Managing clinic.

b. Interviewing patients, including counseling and amplifying the physician's recommendations.

c. Providing essential information about patients to the physician.

d. Making plans with the physician and the patient for follow-up care.

e. Acting as liaison with community agencies.

f. Giving immunizations, penicillin, and other treatments according to the physician's orders for which the skills and knowledge of the professional

nurse are essential, if there is no other person qualified to do this.

Large clinics should have laboratory technicians to do the technical work that does not require a public health nurse. All clinics should make sure that aides or clerks are present to perform nonprofessional functions. In so far as possible, volunteers should also be enlisted to help.

7. Parttime nursing service to industries that are hazardous or essential to national security.

In providing parttime service to industry, agencies are urged to establish priorities within this service in accordance with the "Statement on Principles with Regard to Essentiality of Industrial Nurses for Civilian and Military Defense Needs" prepared by the American Association of Industrial Nurses.[3] This recommends that in the event of a national emergency industrial health service be limited to caring for acute illnesses and injuries, both occupational and nonoccupational, and that the service include a preventive program sufficient only to keep workers on the job at maximum productiveness.

8. Service in schools for selected nursing activities.

As with parttime nursing in industrial plants, it is recommended that nursing service in schools be limited to caring for acute injuries and illness, and include a preventive program sufficient only to keep staff and pupils at productive work.

Some of the previous recommendations apply particularly to public health nurses as they work in schools. Especially pertinent are the recommendations concerning service to persons with specific communicable diseases and assistance with mass education of civilians in home nursing technics and preventive measures. It will be necessary for nurses working in schools to see that well children are protected from contact with those having any communicable disease; that school personnel, school children, and parents are given necessary group instruction in protective health measures; and that those school children who will benefit most from follow-up care are given first preference.

It is essential that nurses in schools carry out only those functions that are important and require public health nursing skills and judgment. These include:

a. Interviewing parents, teachers, and pupils as required for health counseling.

b. Reviewing the physician's recommendations and making a plan with parent or pupil for follow-up of those recommendations.

c. Assisting teachers so they will be ready to observe the health of the children in their classrooms and to see that plans for follow-up are carried out.

Nurses working in schools are occasionally expected to perform duties that properly belong to another worker—teacher, clerk, or attendance worker. All these duties should be allocated to the proper person. It is not necessary to have a person as fully prepared as a public health nurse to assist a physician during medical examinations. Therefore, this assistance should be given by a clerk or aide, paid or volunteer.

The NOPHN School Nursing Section is giving further study to the question of desirable nursing service to the school-age child. These recommendations will be published as soon as possible.

9. Mental health service as an integral part of all public health nursing.

Public health nurses can make an invaluable contribution to civilian morale. Because the problems of living under total mobilization may add greatly to the stress and strain of everyday life, some families will be in special need of finding a release for their tensions. A public health nurse can help provide for this release by recognizing the added emotional factors influencing families during this

[3] American Association of Industrial Nurses. *AAIN News Letter*, March 1951. A limited number of copies is available from AAIN, 654 Madison Avenue, New York. Price, 15 cents each.

period and by giving them an opportunity to discuss their problems.

Such an opportunity offers support to families. Discussing their problems and troubles with a professional person who is a neutral sympathetic listener and in whom they have confidence becomes a means of releasing some of their tensions. When a nurse is able to give strength to families in this way, she is offering a tangible and valuable service.

Mental health, like nutrition, is not a separate service, but should be an integral part of all services a public health nurse offers.

Services that can be eliminated

Not only should priorities be established for the most essential services but any that are nonproductive or nonessential should be cut to a minimum or eliminated. In some instances, weighing the relative needs of certain types of patients is understandably difficult.

The task of limiting service can be made easier if agencies will enlist the natural desire of most people to be of help during a crisis. If the necessity of limiting services is skillfully explained, people generally will understand and cooperate. Simple leaflets, radio programs, newspaper articles can all help further the interpretation.

It is recommended that the following services be cut to a minimum or discontinued:

1. Appointment service for home visits.

Many agencies no longer sponsor an appointment service for home visits; nor do they keep a nurse on call for evening visits. They have found these services costly, administratively unwieldy, and wasteful of professional nursing time. It is advisable for the few agencies which still provide these services to discontinue them. All agencies, however, will find it necessary or desirable to make visits at a specific time of day to some types of patients, such as those who receive certain hypodermic injections and medications.

2. Service to patients requiring simple or custodial nursing care when there is a member of the family to give it.

It has long been the custom for most agencies to teach a member of the family to assume responsibility for giving simple or custodial care. If any agencies still send nurses to give this care, even though somebody else is available and able to give it, they are strongly urged not to do so any longer. However, families should be encouraged to call the agency providing public health nursing if from time to time treatments are needed that only the public health nurse can give. If there are no relatives or other persons to give necessary care, it may be necessary to continue service although it may be possible to reduce the number of visits.

3. Home visits to normal maternity patients who are attending mothers' classes and who are under private or clinic medical care.

Rather than have public health nurses routinely visit the homes of normal maternity patients, communities are urged to develop a plan for giving these patients more group instruction. In some places, it may be preferable for a hospital to provide this instruction; in others, it may be better for the public health nursing agency to give it.

4. Home visits to certain types of patients receiving adequate treatment for syphilis.

It is recommended that, in general, agencies discontinue home visits to patients receiving adequate treatment for syphilis. Instead of making home visits to encourage patients to secure or continue treatment, agencies might telephone or send letters or telegrams urging them to call at the office, school, or clinic. If it is desirable to send special letters to selected patients, these should be dictated by a public health nurse. Form letters can be sent by nonnurse personnel. These recommendations are made not only because nurses' time will be saved but also because experience shows that, with most patients, telephone calls and letters are often more effective than home visits.

If persons with syphilis are not under treatment, or if they do not respond to the methods referred to above, or if contacts do not present

themselves for adequate diagnostic examinations, then all possible means (including home visits, if necessary) should be used to get them under treatment. Priorities for such home visiting are: (1) pregnant women with syphilis (2) infants and children with congenital syphilis (3) adolescents with syphilis and (4) other patients with primary or secondary syphilis.

5. Visits to orthopedic patients to whom service has been given for a reasonable length of time and who have reached a plateau in progress, or for whose rehabilitation the family does not assume its share of responsibility.

Some agencies may find special difficulty in deciding to ration service to the orthopedic patient. Adoption of a definite policy will help, provided it takes into account each patient's individual requirements and makes sure that treatments are reduced or omitted for those patients who will suffer least.

Redistribution of public health nurses

The Joint Committee on Nursing in National Security of the six national nursing organizations has recommended that, if there is total mobilization, nurses be redistributed within the fields of nursing and within community agencies so that the most essential civilian needs will be taken care of first.[4] When applying this recommendation to public health nursing, it is important that any redistribution of public health nurses be carried out first within a community (county or city) next within a state, and then within a group of neighboring states or a region.

Redistribution within a community

The soundest approach to the problem of redistribution of public health nurses is on a community rather than an agency basis. That is, communities should look at their health problems as a whole, deciding which services are most essential and should receive priority, regardless of the agency providing them. This decision should automatically indicate whether the number of public health nurses providing services that must be considered least essential is out of balance with the number of those providing services to which priority should be given.

Because there are so many different patterns for public health nursing in the various communities of the United States, it would not be sound to recommend any one type of organization for all communities even during full mobilization. The following recommendations are made in the hope that they will help communities plan as effectively as possible so that most essential needs will be given top priority and public health nursing time stretched as far as possible to cover basic services:

1. That health departments, visiting nurse associations, and school nursing service administrators plan together to make sure that the entire community is provided with essential service.

Wherever possible, administrators should try to assign "for the duration" one public health nurse to each area of the community to give a generalized service. Small agencies may be able to do this throughout the community. In large cities, such a plan may be possible in some sections if not in all.

2. That in a rural area there be only one public health nursing service.

The many advantages of including rural school nursing in a generalized public health nursing service are generally recognized.

3. That the boards of directors of agencies devoted to the care and eradication of specific diseases (such as tuberculosis, cancer, infantile paralysis, heart disease) assign any public health nurses they now employ to generalized public health nursing agencies and pay their salaries.

In this way all public health nurses in the community will be available to give all the necessary services, including those to patients with the specific diseases in which the special health agencies are interested.

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[4] Joint Committee on Nursing in National Security. Mobilization of nurses for national security. PUBLIC HEALTH NURSING, February 1951, v. 43, p. 65-68.

4. That, when feasible, nurses employed by boards of education help give essential public health nursing service in the community.

If a careful analysis of the present activities of nurses employed by boards of education shows that they are carrying out nonnursing functions in the schools, these functions should be assigned to other personnel. (See page 263.) Then it will be possible for those nurses to help give essential public health nursing service in the community to persons of any age.

5. It is especially important as pressures on public health nursing services increase that transportation by automobile be provided in all areas where adequate public facilities are not available and where distances between visits are great and walking is wasteful of nurses' time.

Nurses may prefer, especially in rural areas, to have assistance in buying and maintaining their own cars and to receive adequate reimbursement for milage on duty rather than have agency-owned cars provided.

Redistribution within a state or area

At present the nation has approximately one public health nurse for every 6,000 persons. However, this ratio does not hold constant for all communities. Some have one public health nurse for fewer persons; many have only one for as many as 20,000 or more persons. Defense and military areas and other rapidly expanding communities with mounting health problems, are likely to have very unfavorable ratios.

During mobilization it is more vital than ever that there be equitable distribution of public health nurses according not only to population but also to number and kinds of health problems. Stable communities having reasonably adequate facilities should be asked to release some public health nurses to the expanding areas that do not have any public health nursing service or at least any comparable to that in the more stable areas. Those public health nurses who have been released should be reassigned to other communities, preferably on a voluntary basis, but if that does not work, then on a mandatory basis. If it is to be mandatory, then a state, regional, or federal agency may have to be designated to take charge of the redistribution.

It should be recognized, however, that relocating public health nurses may impose a hardship upon them and their families. Provision should be made for housing a public health nurse's dependents, if any, in the new community; or some financial allowance should be made if it is necessary for them to remain in the community where the public health nurse previously worked.

Administrative adjustments and new emphases

Giving priority to the most essential services and eliminating any that are nonessential will call for many modifications in agency administration.[5] Intake policies for even the essential services will need careful and frequent review. Wider spacing of visits may be necessary. Every conceivable means of cutting down any nonproductive visits and nurses' travel time should be used.

Some other means of extending service as far as possible and meeting priorities in the community are:

1. Planning with hospitals.

It will be more important than ever for hospitals and public health nursing services to plan and work closely together. It is an economy for as much instruction as possible to be given to patients while they are in the hospital. The content of teaching in both home and hospital should be the same. Patients leaving the hospital who need care at home should be referred to the agency providing public health nursing service.

2. Making the most advantageous use of community facilities.

Communities will, of course, want to make the most advantageous use of all available

[5] Vaughan, Margaret S. Priorities for public health nursing visits. PUBLIC HEALTH NURSING, January 1951, v. 43, p. 17-20.

facilities to further their health programs. Because schools are already established and usually have space, equipment, and personnel available, they can be used in an emergency for such measures as immunizations if regular community facilities are overtaxed.

3. Employing practical nurses.

Public health agencies providing bedside nursing care to the sick should employ practical nurses who are licensed to practice if licensure is provided in the state. These should preferably be graduates of approved schools of practical nursing. If no licensure is provided in a state, it is recommended that agencies employ those practical nurses whose educational background and experience meet the standards of the association sponsoring the registry that serves practical nurses, and whose references are acceptable to the registry committee.[6] The criteria for the assignment of practical nurses for service in a home should be the condition of the patient and the particular situation in the home. In general, it is recommended that practical nurses be employed to give the following services, under the supervision of a public health nurse, provided no member of the family is available or able to give them:

a. Simple nursing care to a person if he and his family do not require much instruction.

b. Simple treatments.

c. Hypodermic injections of well known drugs that require no fractional dosage.

In addition, some agencies assign the following duties to practical nurses when a member of the patient's family is unable to give care: simple dressings, assistance to the patient in practicing crutch walking, high colonic or colostomy irrigations. In some agencies a practical nurse gives the following medications either subcutaneously or intramuscularly, provided a public health nurse plans with her for each specific situation: vitamins, crude and refined liver, insulin, penicillin, mercurials including thiomerin, and hormone products.

Certain principles in the administration of practical nurses' services are important.[7] First, practical nurses should be considered an integral part of the nursing staff although their responsibilities are not the same as those of public health nurses. Next, it should be emphasized that they do not "take over" a patient's care but share aspects of that care with a public health nurse who is responsible for the patient's welfare and progress from the public health nursing point of view.

Even as practical nurses need some orientation to their work in a public health nursing service, so do staff nurses need some help in understanding the role of practical nurses in each agency where they are employed.

It is impossible at this time to recommend any definite ratio of practical nurses to public health nurses. In some agencies it may be desirable to have one qualified practical nurse to ten professional nurses. In other agencies, depending on local circumstances, one qualified practical nurse to five or six professional nurses may be a preferable ratio.

4. Employing auxiliary workers, paid or volunteer.

Aides and clerks should be employed in clinics to perform all tasks that do not require nursing skills. Clerks should do as much as possible of the record and clerical work.

Every effort should be made to enlist the help of volunteers, and, what is more important, to help make the services of volunteers as effective as possible. It is advisable for volunteers to be directly responsible to a member of the paid staff for the performance of their tasks, but to work under the leadership of another volunteer, usually the chairman of a committee on volunteers. A member of the professional staff should act as consultant to the volunteer leader. It is also essential that careful attention be paid to the other important principles of a successful volunteer program so that the help of volunteers

[6] American Nurses' Association. American Nurses' Association registry manual. 1948. Pages 14-15.

[7] Phillips, Elisabeth C. Practical nurses—of course we employ them! PUBLIC HEALTH NURSING, December 1950, v. 42, p. 663-667.

may be of maximum productivity.[8]

5. Employing parttime workers, professional and others.

Many capable and well prepared women cannot work full time because of extensive family responsibilities. Yet they have a valuable contribution to make on a parttime basis. Their services should be secured whenever possible.

There are a number of responsibilities that can be handled satisfactorily, after adequate orientation, by qualified public health nurses who can work only part time, such as giving service in some schools and giving instruction and demonstrations at fathers' and mothers' classes. Arrangements can often be made for two parttime public health nurses to share one district. Sometimes clerical assistance can be given by a clerk who works two or three days a week or only weekday mornings or afternoons.

6. Simplifying records and reports.

Every agency should review its procedures in regard to records, eliminate nonessential items, simplify the reporting and recording system, and avoid duplication of information.

The usefulness of records is often reduced after a certain period of time, but considerable work may be involved in keeping and storing them. It is therefore recommended that agencies adopt practical policies for the destruction of records that have not been used for two or three years, provided the law does not require that they be kept longer. During a critical period an agency might also omit some detailed statistical tabulations that may normally have been considered desirable.

7. Assisting staff nurses to streamline their services.

The successful streamlining of public health nursing for minimum essential service will depend in very large measure upon staff nurses. They should be given the opportunity to plan together in changing the nature and scope of their services. They should also take part in planning for any new policies that will be adopted.

It will be especially important for staff nurses to understand why they are needed in civilian agencies,[9] how to assume added duties if there is a real crisis, how to streamline their services and yet intensify their training of families so they can help themselves as much as possible, and how to work effectively with practical nurses and nonnurse helpers, including volunteers.

8. Adapting personnel policies to new conditions if there is further mobilization.

If the situation becomes such as to make a longer work week necessary (but not more serious than is forseeable at present) the number of working hours in a week should be increased to no more than forty-four. It is not recommended that public health nurses work forty-eight hours unless there is an extreme emergency. Experience has shown that if people work longer hours, they do not necessarily accomplish more. Very often there are diminishing returns in productivity if more than forty-four hours a week are required for any length of time.[10]

Then, too, many public health nurses have families for whom they have housekeeping and shopping responsibilities. A forty-eight hour week would work a hardship upon them and would not be in the best interests of health.

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[8] Wensley, Edith. The community and public health nursing. N. Y., Macmillan, 1950. Chapter 15.

[9] National Organization for Public Health Nursing. Public health nursing in the national security program. PUBLIC HEALTH NURSING, February 1951, v. 43, p. 69-72.

[10] State of New York Department of Labor, Division of Industrial Relations. Health and efficiency of workers as affected by long hours and night work: experience of World War II. August 1946.

Kossoris, M. D. Studies of the effects of long working hours. Parts 1 and 2. Bulletin Nos. 791 and 791A. U. S. Department of Labor, Bureau of Labor Statistics, 1944.

If public health nurses are required to increase their present work week to forty-four hours, they should be paid for the extra hours beyond the number now required.

If, in a general redistribution, public health nurses are asked to go to a different community, they should be paid a salary that will compensate them for the change, for the extra expense involved in moving, and for a higher cost of living, if it exists in the area to which they are transferred. They should also be helped to find living quarters in the new community not only for themselves but for any dependents.

9. Establishing priorities for supervised field instruction.

The NOPHN Education Committee is currently recommending that "public health nursing services should make their facilities for field instruction available first to those groups who, because of such instruction, will at once increase the number of qualified nurses in public health nursing services."[11] The groups that should receive priority are: (1) students enrolled in basic collegiate and graduate nurse educational programs approved for public health nursing by the National Nursing Accrediting Service (2) students enrolled in collegiate programs in nursing not yet approved by the National Nursing Accrediting Service but which have as one of their stated objectives the preparation of nurses for beginning public health nurse positions under supervision (3) nursing faculty teaching in collegiate schools of nursing that prepare nurses for the positions mentioned above (4) graduate nurse students in universities who are preparing themselves for faculty positions in collegiate programs.

It is recommended that agencies providing field instruction give priority to the groups just mentioned. A satisfactory method for ensuring automobile transportation for students in areas where public transportation is not readily available is much needed. An NOPHN committee is working on this problem and will publish its recommendations as soon as possible.

10. Providing for supervision.

Of extreme importance during normal times, good supervision of both experienced and inexperienced nurses will be even more important if mobilization increases. Many staff nurses will be drawn from the inactive group or from those without any public health nursing preparation or experience. The better prepared and more experienced staff nurses will have more responsibility for the supervision of the less experienced nurses and auxiliary workers. Some nurses who may be transferred from "specialized" to "generalized" agencies will need intensive supervision, at least until they become adjusted to the different kind of work.

Accordingly, it is important that agencies provide for continuous supervision of all the staff. Generally, one supervisor is needed for every ten staff nurses. However, there are variations to this ratio, depending on whether or not a program is generalized, staff nurses are well qualified and well adjusted, and an agency provides field instruction to students. If an agency has a completely generalized program or if it regularly accepts students for instruction, one supervisor may be required for eight or nine staff nurses. If an agency provides mainly a bedside nursing service, one supervisor to ten staff nurses may be adequate.

11. Providing for staff development while on the job.

In addition to supervision, it will be important for public health nursing services to continue staff development programs, including emphasis on the mental health aspects of all public health nursing.

Through an inservice educational program new nurses without public health nursing preparation or experience will be helped to understand public health nursing, and all nurses will keep posted on new developments

[11] National Organization for Public Health Nursing. Priorities in public health nursing education. PUBLIC HEALTH NURSING, January 1951, v. 43, p. 34-40.

in nursing and medical procedures which may occur even more rapidly than in the past.

Recruiting students and inactive nurses

Even if the present situation stops short of fullscale hostilities, the nurse supply should be increased to make up the current deficits in essential services and to keep up with the needs of a growing population. If total war should develop, the nurse supply should be further increased to provide for additional military nursing needs. The problem of recruiting more students and encouraging inactive nurses to return to practice is therefore urgent.[12]

To safeguard essential service, agencies should lend all possible assistance to any community plan for recruiting students and encouraging inactive nurses to return to practice. Agencies should also encourage the preparation of personnel for essential supervisory and administrative posts and for the special fields, including public health nursing, requiring preparation beyond that given in the basic school of nursing.

Nurses who have public health preparation and experience will be especially needed in public health nursing services. Therefore, inactive public health nurses should be urged to return to the public health field, full time or part time, rather than in hospitals or other agencies where their special preparation and experience might not be put to the most advantageous use.

Summary

Because of the increasing demand for nurses and the urgent need to reach a maximum number of persons if there is full mobilization, it is recommended that communities establish priorities for the most essential public health nursing services and cut to a minimum or discontinue those that are least essential.

It will be of the utmost importance for public health nursing services to review their programs and procedures; to make necessary adjustments so that the most essential services will be provided to the persons who most need them, and nurses' time put to the most advantageous use for the greatest good of the community. Some of the adjustments may be temporary; others may inevitably become permanent. All agencies should accordingly make careful plans, with both the emergency and the long term future in mind, so that all adjustments will result in only minimum damage and possibly in some permanent gains.

To reach as many persons as possible, agencies may find it necessary to shift emphasis from the individual family to the group, that is, from individual to mass technics. Although expedient and necessary under emergency conditions, this shifting emphasis should not be considered permanently desirable. Family health teaching is still the basis of good public health nursing and should be the basis of all public health nursing programs when agencies are not under the necessity of taking emergency shortcuts to provide essential service with minimum personnel.

Nobody knows how long the "emergency" now facing the nation will last, nor how many adjustments will ultimately be called for. It is certain, however, that agencies will do everything possible to provide those services that are fundamental to good health and civilian morale.

[12] Joint Committee on Nursing in National Security. Mobilization of nurses for national security. PUBLIC HEALTH NURSING, Febuary 1951, v. 43, p. 65-68.

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Public Health Nursing Test

The APHA Merit System Service offers a New Test

DOROTHY DEMING, R.N.

EARLY IN THE SPRING of 1950 the Merit System Service of the American Public Health Association prepared a new student test intended for a new purpose: to assist in measuring the students' knowledge of public health nursing principles upon completion of program in collegiate schools of nursing. During the spring and summer the test was pretested on some 500 students enrolled in both approved graduate nurse programs in public health nursing and in collegiate basic schools. This is a report of the experience with the test to date and conclusions as to its usefulness.

The test consists of 180 objective-type questions in the following subject matter areas:

- Public health nursing
- Maternity and infancy
- Child health
- Noncommunicable diseases
- Communicable diseases
- Venereal disease
- Tuberculosis
- First aid
- Nutrition
- Mental health
- Health education
- Background-trends and developments in public health

Questions range from straight "recall" type (for example: who wrote *Public Health Nursing Practice?*) to "judgment" questions (for example: Which of the following steps should a public health nurse take first in the event of an outbreak of food poisoning following a church supper?). All questions offer five choices from which the examinee chooses the one best, most correct answer. The questions take approximately three hours to answer. All testing materials, scoring service, and interpretation of scores are supplied by the Merit System Service. During the pretesting period the test was offered without charge. (However, schools could obtain individual "profiles" for each student at a charge of $1 each.)

Of the 442 completed answer sheets which were suitable for analysis by the statistical department of the Merit System Service, 101 were from students in collegiate basic schools which are preparing nurses for entering public health nurse positions, the remainder—341—were from public health nursing students in the graduate nurse program of study. The average raw score for both groups combined (that is, the average number of items answered correctly out of 180) was 121.31. The average basic collegiate school student's raw score was 119.21; the average graduate nurse student's, 121.90. The range of raw scores for the basic collegiate group was 86-151; for the graduate nurse group, 76-155. The difference in total scores is not significant.

Further examination of the student scores in the various subject matter areas revealed some interesting facts. The collegiate basic

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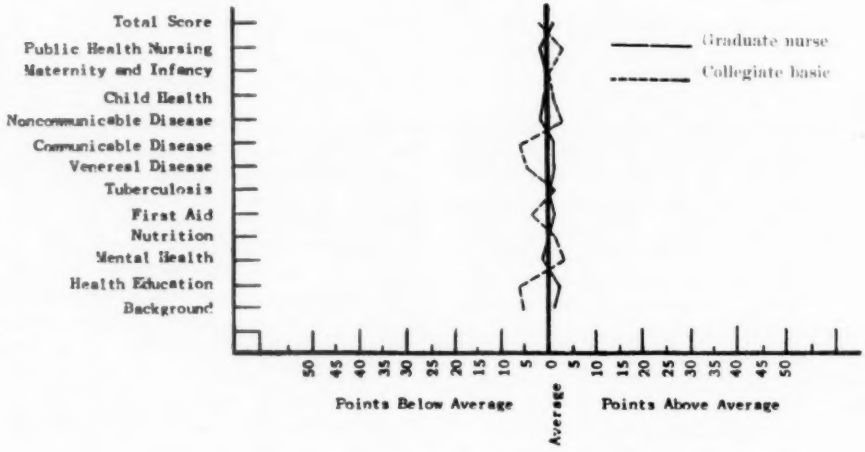
school students showed a significant weakness in their knowledge of the public health aspects of the following subjects: communicable diseases, venereal disease, health education, and background knowledge, that is, trends, developments, and resources. This group, however, scored significantly higher than the graduate nurse program students on the noncommunicable disease section. There were no significant differences in scores in the other subjects. The accompanying "profiles" of performance of both groups show these results graphically. The dotted line represents the basic collegiate group scores, the solid line represents the scores of the graduate nurse students.



IN GENERAL, it may be said that the students' reaction to the test and test experience was favorable. The content, phraseology, and approach in a few items were questioned. Some of the students said the test was too long, one group felt it was too difficult. Actually the test has not proved to be too difficult for either group according to modern testing standards. All concrete criticisms were welcomed.

The evaluation program of the Merit System Service will include a validation of this test against college grades or faculty ranking of the students taking the tests. The test will be reviewed and revised in the light of experience with the statistical analysis of the results and the comments from both the students and the faculty. It is anticipated that the test will be studied and appraised by a consultant group within a year or two.

The Public Health Nursing Test is now ready for general use. It is especially recommended to collegiate basic schools of nursing which would like to have a measure of the knowledge of public health nursing principles possessed by their students upon completion of the whole collegiate program. The test may be ordered from the Merit System Service. The cost is $2 a student. This includes all scoring service, an interpretation of scores, and an individual profile for each student showing her performance in each subject matter area as compared to the average performance. Complete instructions accompany the tests and the scores are reported within a few days of receiving the answer sheets. The purchaser pays return mailing costs. The test material is released under strict security regulations in order to preserve the confidential nature of the questions and the identity of the students and the schools.

For information about this test please write to the Merit System Service, 1790 Broadway, New York 19.

SUMMER OFFERINGS FOR PUBLIC HEALTH NURSES

Summer Offerings in Universities and Colleges Having Educational Programs Approved for Public Health Nursing by the National Nursing Accrediting Service

California

Berkeley. University of California. June 18-July 28. The Field of Public Health Nursing (open only to graduate nurses with junior standing, eligible for admission to the School of Nursing, Berkeley). June 18-July 6. Institute on Counseling in Nursing.

For further information write to Department of Nursing, 3574 Life Sciences Building, Berkeley 4.

Los Angeles. University of California. June 18-August 11. Social Work Methods and Nursing; Survey of Nursing; Maternal and Child Health; Changing Perspectives in the Nursing Profession; Field Experience in Public Health Nursing (enrollment restricted to upper division students who have been in residence at UCLA in the spring 1951 semester). July 23-August 10. Interpersonal Relationships in Nursing.

For further information write to School of Nursing, 405 Hilgard Avenue, Los Angeles 24.

July 9-July 20. Maternity Nursing.

For further information write to Myrtle Findley, University Extension, 10851 Le Conte, Los Angeles 24.

Illinois

Chicago. Loyola University. Intersession, June 18-20. Institute on Aging—a New Focus. June 20-22. Institute on Mental Health—Effective Relationships. Summer Session, June 25-August 3. Principles and Organization of Public Health Nursing I; Principles and Organization of Public Health Nursing II; Principles and Organization of Public Health Nursing III; Principles of Supervision in Nursing; Field Work in Public Health Nursing.

For further information write to Essie Anglum, Chairman, Department of Public Health Nursing, 820 N. Michigan Avenue, Chicago 11.

Missouri

St. Louis. St. Louis University. Intersession, June 4-June 15. Workshop in Guidance; Institute on Posture in Health and Disease. Summer Session, June 18-July 27. Mental Hygiene; Methods of Teaching in Nursing; Clinical Instruction in Nursing; Human Physiology; Principles and Practices of Supervision. June 18-June 29. Institute on Tuberculosis Nursing. July 2-July 13. Institute for Nurses on Cardiovascular Disease. July 16-27. Institute on Nutrition for Nurses and Allied Health Workers.

For further information write to Lucille B. Becker, School of Nursing, 1402 South Grand Boulevard, St. Louis 4.

New Jersey

Newark. Seton Hall University. July 2-August 10. Principles of Public Health Nursing; School Nursing; Introduction to Social Case Work; Introduction to Supervision in Public Health Nursing; Nutrition and Health; Child Growth and Development; Educational Psychology; Mental Hygiene; Principles and Techniques of Teaching. Courses in English, social studies, and philosophy will also be given.

For further information write to the Dean, School of Nursing, 40 Clinton Street, Newark 2.

New York

Brooklyn. St. John's University. Intersession, June 4-28. Methods of Teaching Home Nursing and Child Care in Secondary Schools.

For further information write to the Dean, School of Nursing Education, 303 Washington Street, Brooklyn 1.

New York. Columbia University, Teachers College. July 2-August 10. Foundations of Nursing Education; Foundations of Nursing Education: Advanced; Physiology and Functional Anatomy; Introduction to Microbiology.

July 2-20. Studies in Nursing Service and Nursing Education (also offered July 23-August 10). Mental Hygiene in Nursing.

July 2-13. Work Conference for Nurses on Planning a Health Program for the School Age Child; Work Conference for Nurses on Maternal and Child Health.

For further information new students write to Office of Admissions, former students to Division of Nursing Education, both at 525 West 120 Street, New York 27.

New York. New York University. June 4-15. Quantitive Evaluation of Health Records. July 2-August 10. Fundamentals of Teaching in Nursing. August 13-24. The Teaching Activities of the Public Health Nurse. August 27-September 7. Introduction to Supervision in Public Health Nursing.
For further information write to Blanche L. George, Director of Public Health Nursing, 49 South Building, Washington Square, New York 3.

Oregon

Portland. University of Oregon Medical School. June 10-June 29. Public Health Nursing Supervision.
For further information write to Director, Department of Nursing, Portland 1.

Pennsylvania

Philadelphia. University of Pennsylvania. June 25-July 13. Special Phases of Public Health Nursing: Services Relating to Maternity, Infancy, and the Preschool Child. July 16-August 3. Special Phases of Public Health Nursing: School Nursing.
For further information write to Theresa I. Lynch, Dean, School of Nursing, 3629 Locust Street, Philadelphia 4.

Pittsburgh. Duquesne University. July 2-August 10. Principles of Public Health Nursing; Public Health Nursing Services I (Maternal and Child Health); Teaching in Public Health Nursing.
For further information write to Grace Frauens, Director, Public Health Nursing Program, 801 Bluff Street, Pittsburgh 19.

Pittsburgh. University of Pittsburgh. June 18-29. Special Health Problems of the School Child. July 2-August 24. Nutrition of the School Child.
For further information write to Professor Dorothy Rood, Chairman, Department of Public Health Nursing, Pittsburgh 13.

Virginia

Richmond. Medical College of Virginia. May 28-June 8. Supervision in Public Health Nursing.
For further information write to C. Viola Hahn, Director, Public Health Nursing Program of Study, Richmond 19.

Washington

Seattle. University of Washington. June 18-July 18. Principles in Public Health Nursing; Communicable Disease Control; Methods of Interviewing (for advanced students). July 19-August 17. Public Health Organization; Family Budgeting June 18-August 17. Special Fields in Public Health Nursing; School Health Programs, Public Health Nursing Aspects of Adult Hygiene.
For further information write to Mrs. Lillian B. Patterson, Dean, School of Nursing, Seattle 5.

Wisconsin

Madison. University of Wisconsin. June 25-August 17. Principles in Public Health Nursing; Special Services in Public Health Nursing; Maternal and Child Health.
For further information write to Martha R. Jenny, Associate Professor of Public Health Nursing, School of Nursing, 1402 University Avenue, Madison 6.

Milwaukee. Marquette University. June 22-August 3. Principles of Public Health Nursing; Special Fields in Public Health Nursing; Maternal and Child Health; Applied Microbiology; Principles and Methods of Teaching; Integration of Social and Health Aspects. Academic subjects required for B.S. in Public Health Nursing. July 9-10. Institute on Public Health.
For further information write to Anna Hassels, Director, Program of Study in Public Health Nursing, 3058 North 51 Street, Milwaukee 10.

"Hearing Is Priceless—Protect It!" is the theme for National Hearing Week May 6-12. Sponsored by the American Hearing Society and its 115 local chapters, the week is designed to focus attention on the extent of our hearing problem. An estimated 15,000,000 people, including some 3,000,000 children, have some hearing impairment.

The Two Organizations in the New Structure

This is the second in the series of articles reporting progress in completing the design for the new national nursing structure. Members of the national nursing organizations participating in the plan for reorganization are urged to save these articles which are intended to take the place of the 1949 Handbook on the Structure of Organized Nursing. *The series will present a complete description of the plan for the new structure and should be used for reference when members or delegates vote on the final plan.*

THE DESIGN FOR the new structure is rapidly taking shape. The Joint Coordinating Committee on Structure of the participating national nursing organizations, with the help of each organization's committee on structure, has developed a statement of the purpose and functions of the two organizations in the proposed new structure. If approved by the boards of directors this will form the basis for the constitutions of the organizations in the new structural plan, which will be presented to the members or delegates of the participating organizations for their vote during the spring of 1952.

Here is the statement, together with a diagram of the proposed new structural plan.

In 1950 the members of six national nursing organizations* voted to realign into two national nursing organizations—one an all-professional organization composed exclusively of nurses, the other an organization whose membership may include nonnurses, nursing service agencies, and schools, as well as nurses. It is proposed that these organizations be the American Nurses' Association and the Nursing League of America.

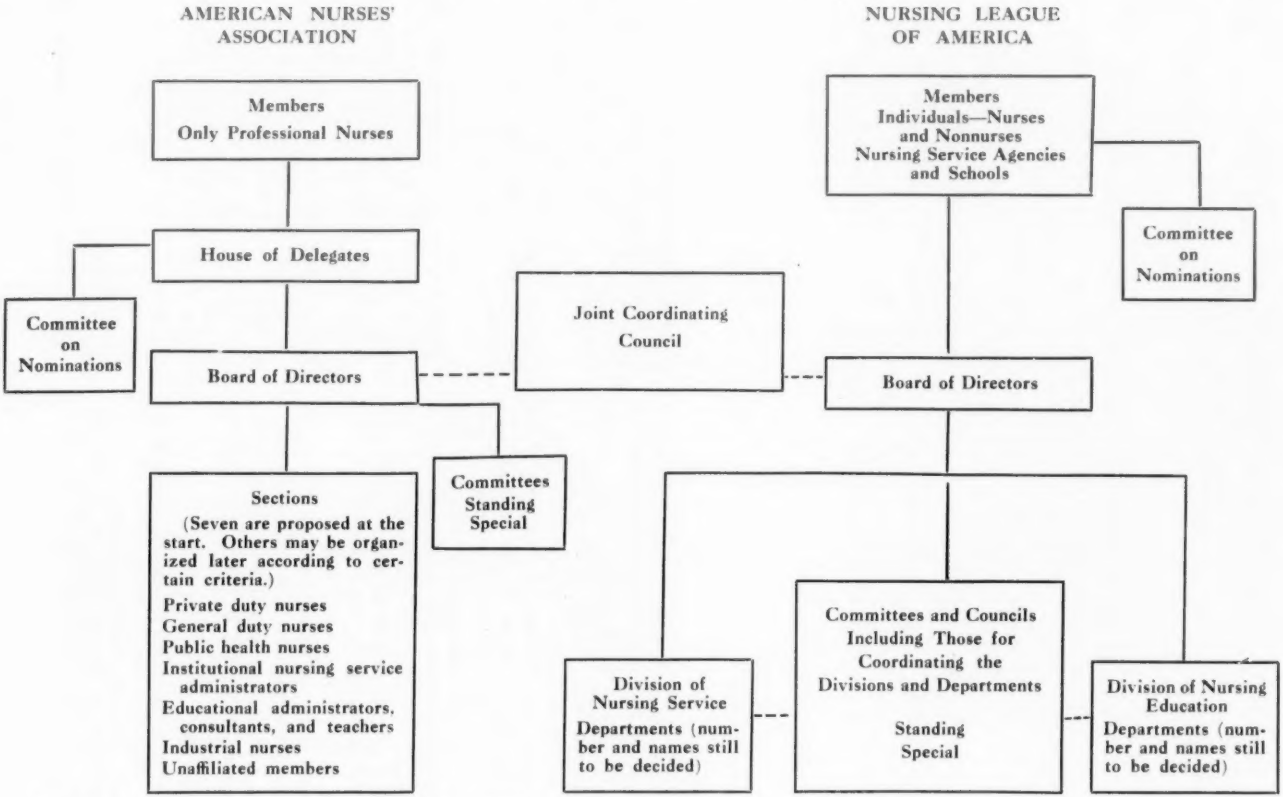
Both organizations will have a common overall purpose—to further the development of the best possible nursing service for the people of the United States of America. In addition, each organization will have its own distinct purpose and functions in line with the needs and interests of its members.

In general, the American Nurses' Association will be concerned mainly with nurse practice—that is, with nurses as individual practitioners and as members of a profession. In a broad sense the ANA will deal with matters that are related to the individual nurse's responsibility for becoming the best possible practitioner and also with her economic and general welfare.

The Nursing League of America will be

* American Association of Industrial Nurses, American Nurses' Association, Association of Collegiate Schools of Nursing, National Association of Colored Graduate Nurses, National League of Nursing Education, National Organization for Public Health Nursing.

PLAN FOR TWO ORGANIZATIONS*



* As plans develop diagrams in more detail will be published.

concerned mainly with the ways in which organized nursing service is provided to the people who need it and the ways of providing nurses with the education they must have to give good nursing service. These are responsibilities that can and should be carried out not only by nurses in all fields and in all types of positions but by the people themselves as supporters and consumers and by members of other professional and allied groups.

Although it is essential for sound administration and operation that the purpose and functions of each of the two organizations be distinct and as mutually exclusive as possible, close cooperation and coordination of activities will be of basic importance. The machinery for such cooperation and coordination of activities will be provided through a joint coordinating council; through representation on each other's appropriate committees; through conferences and close working relationships of the chief executives and other staff members of the two organizations.

Purpose and functions of ANA in the new structure

The purpose of the American Nurses' Association shall be to foster high standards of nurse practice and to promote the welfare of nurses through the coordinated action of organized nurses.

The functions of the American Nurses' Association shall be:

1. To define functions and promote professional standards of nurse practice.
2. To define qualifications for the practitioner of nursing, including those in the various nursing specialties.
3. To promote legislation and to speak for nurses in legislative action in general health and welfare programs.
4. To survey periodically the nurse resources of the nation.
5. To promote and protect the economic and general welfare of nurses.
6. To provide professional counseling service to individual nurses and their employers in regard to employment opportunities and available personnel.
7. To cooperate with the NLA in activities of concern to both organizations.
8. To represent nurses and serve as their national spokesman with allied professional and governmental groups and with the public.
9. To serve as the official representative of American nurses in the International Council of Nurses.

Purpose and functions of NLA in the new structure

The purpose of the Nursing League of America shall be to foster the development and improvement of nursing services and nursing education through the coordinated action of nurses, allied professional groups, general citizens, agencies, and schools to fill the nursing needs of the people of the United States of America.

The functions of the Nursing League of America shall be:

1. To define and promote standards for organized nursing services and to stimulate and give guidance to communities and service agencies in applying these standards to bring about effective organization, administration, and utilization of personnel.
2. To promote education for nursing in all fields by defining and developing sound standards of nursing education and by planning the development of adequate facilities for good organization, administration, and curricula.
3. To provide consultation and other services within the purview of the NLA to individuals, agencies, schools, and communities.
4. To promote the extension and proper distribution of facilities for nursing services and education throughout the country.
5. To cooperate with the ANA and allied groups in planning for legislation and other activities that affect nursing and health and in interpreting them to NLA members.
6. To represent nursing services and nursing education and to serve as spokesman with allied professional, governmental, and international groups and with the public in matters related to the purpose of the NLA.

This article appears also in the *American Journal of Nursing*, May 1951.

Teamwork in the Prevention of Hearing Impairment in Children

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THE INCIDENCE OF hearing impairment among children is a sizable national problem and, in view of the grave consequences for growth and development, a vitally important one. Coordinated community action is needed for early casefinding and treatment which can often prevent the development of a serious handicap with all its consequences for growth and development.

Approximately 5 percent of our school-age children have some hearing impairment. This figure does not include children suffering the transitory effects of upper respiratory infection. Figures for preschool children are not so definite. The general incidence is probably not so high, but the proportion with severe impairment may be considerably higher. Probably at least one in every twelve to fifteen persons of all ages has a hearing problem. As infant mortality decreases and longevity increases this figure will rise. Yet many gradually developing impairments can be controlled by present diagnostic and therapeutic technics if discovered early.

Recently there has been a nationwide upsurge of interest in the preventive aspects of this problem. In almost half the states the testing of hearing is required by law, usually as part of the school health code. However, there is considerable difference among methods and procedures of casefinding and often inadequate follow-up. One source of confusion may be the way laws are written. There may be ample provision for the handicapped child but little or none for the prevention of the handicap. Sometimes difficulty is caused by the way laws are interpreted and administered, with too little provision for developments in methods and technics. Sometimes confusion is caused by the common shortcoming of "too many cooks." Ideas like the "prevention of deafness" and the "conservation of hearing" are relatively meaningless until they are translated into some sort of concerted action that promotes the health and welfare of the community. Experience has demonstrated that this is best accomplished by teamwork in the community, and, because of the nature of hearing problems, there is good reason to believe that a large part of the preventive job can be accomplished by the use of public health technics.

By and large, of every ten children found to have impaired hearing in an adequate screening examination, two will have permanent impairment not amenable to reversal or sufficient functional recovery by medical and surgical procedures; eight will have hearing losses that can be reversed or greatly relieved by minimal medical care, if the cases are found early and treated adequately. This ratio has been demonstrated by statistics from a wide variety of sources. These figures mean that while 5 percent of school-age children have some hearing impairment about one half of one percent have sufficient hearing impairment to need special training or special handling in school. (We are discussing here

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only the children who have no other handicaps; the figure is considerably greater if multihandicapped children are included.) Much consideration is given this group. At present there are approximately 20,000 children in special schools for the deaf. Many of these are by no means totally deaf but need very special work. Many are not even educationally deaf by present standards but, because of the lack of facilities, cannot be handled in any other way. Many have not had the benefit of adequate diagnosis and treatment prior to admission. The fact remains, however, that a great deal of attention is being paid to the needs of the child with severe or profound hearing impairment. Not nearly so much has been directed to preventive work with the child who has a moderate, mild, or subclinical amount of impairment. Yet, in terms of numbers and amenability to minimal medical care, this is much the more important group.

Design for a Preventive Program

The principal need in most communities is that the various agencies, public and private, capable of doing this job learn to pool their capacities to meet the needs of the child. This is a combined medical and nonmedical undertaking that requires understanding and cooperation. A working program may be developed in various ways, but the general design will probably include something like these seven steps:

1. Public education—health education, if one prefers—to the end that the facts of hearing and hearing impairment may be shared by the entire community for better understanding of the problem in terms of health, behavior, social adjustment, and vocational achievement.

2. Adequate casefinding, which involves the use of careful screening technics for all school-age children and as many preschool children as can be reached, and referral from all agencies concerned with the health and welfare of children.

3. Thorough diagnostic examination.

4. Adequate medical and surgical treatment and thorough follow-up.

5. Audiologic study and consultation (this involves a study of the whole child in terms of behavior related to communication, not simply the hearing mechanism) centered in the problems of the child with a permanent hearing disorder.

6. Special education either in a special school or adjunctive to the regular school, according to the child's needs.

7. Vocational rehabilitation if and as needed.

Obviously, the emphasis on prevention involves steps 1 through 4. This is prevention in terms of the reversal of physical and psychologic symptoms. The kind of prevention that has to do with the arresting of symptoms and the avoidance of serious changes in the personality is what is usually meant by conservation. This work includes all seven steps.

Ideally, the steps in the program should be so organized that there is close interplay under medical direction in casefinding and diagnosis and coordination of both medical and nonmedical aspects of case handling, with genuine insight on the part of physicians, parents, teachers, nurses, guidance counselors, social workers, and everybody else who is in contact with children. There should be smooth continuity and transition between maternal and child care, school health and crippled children's services and vocational rehabilitation, and between official and private service agencies. What part of the work is public and what part private depends upon the facilities of the community concerned. Incidentally, there are several communities, both urban and rural, where such programs have been working for some time.

Hearing and the Dynamics of Behavior

The need for general acquaintance with the nature of hearing and its relation to health and behavior is critical. Most people take hearing for granted, know little about it, and pay little attention to it until something happens to disturb the hearing mechanism. The normal human hearing mechanism is an extremely sensitive analyzer of sound, capable of handling differences in sound pressure multiplied ten million times between the sound that is barely perceptible and the sound so intense that it causes pain. Because of the limits of ordinary conversation only about

half this potential hearing is used in conversational situations. Yet in any typical day every one of us expects to be able to adjust immediately between the faintest whisper and the roar of the subway or the airplane motor. This fine mechanism is subject to several different types and degrees of impairment related to many possible causal factors. Often the trouble can be repaired if it is caught early enough. Sometimes it cannot be repaired, for there is no way to replace damaged nerve tissue in the hearing mechanism.

Hearing, or, better, perceiving and listening, are very much a part of the dynamics of human behavior and adjustment. The determination of the nature and extent of the physical damage and the treatment of it are medical functions that require the highest skill and understanding. The community need not and cannot very well know these details. What it can learn is that hearing is a tool, not an end in itself; that a child learns to talk because and as he hears; that most of our common communication — conversation — is dependent upon the hearing mechanism; that there are dozens of degrees between normal hearing and total deafness; that hearing is very much a part of the dynamics of social and psychologic adjustment.

Unfortunately, a hearing loss does not "show" as a physical defect any more than normal hearing "shows." The effect of any serious amount of hearing loss shows, however, in the individual's lack of ability to communicate freely and easily. In young children the signs may be retardation of speech development, inadequate social development, daydreaming, lack of attentiveness, dullness, or confusion. In adults the problems related to impaired hearing take many forms, from mild discomfort to loss of job and friends. We have only to look around; few of us are without a relative or acquaintance who has impaired hearing.

Hearing aids

Perhaps the matter of hearing aids needs particular attention. Eyeglasses are all right these days. They come in assorted sizes and colors and it is smart to select frames that match one's facial anatomy and decor. Hearing aids, although they are truly wonderful electronic mechanisms, are not yet socially acceptable. They need to become so, for the great majority of children with a speech-hearing impairment in excess of 35 decibels below normal can profitably use amplification, as can great numbers of adults. The total figure of those who would benefit from hearing aids goes into the millions. Yet probably no more than 800,000 are in use even part of the time. A hearing aid is only an amplifier, however, not a panacea; and the aid that will work well for one person is not necessarily suitable for another.

Unfortunately, little as people in general understand hearing and hearing problems, the person with the impairment may understand even less. If the development of the trouble is gradual, he gradually loses touch with the normal world of sound, and often has no way to judge how many related idiosyncrasies he has developed. Understanding some of the relationships involved among adults is not easy. It is even more difficult with regard to children's problems.

Casefinding

In the school health program the problems of casefinding are quite readily solvable. The children are available in school. Good screening technics have been worked out. First-graders and secondgraders are more difficult to test accurately than are children in the third grade and above. There are plenty of facts available for guidance in establishing casefinding procedures. Who does the screening tests is a matter for administrative decision in terms of time, expense, and availability of personnel. It is important, however, that the testers be thoroughly acquainted with audiometric technic and that they know how to handle children. Casefinding is too important to be left with interested but technically untrained volunteers, or to be assigned casually to the public health nurse as one more among many jobs. At the subclinical level speech-hearing tests will miss more cases than pure-tone tests.

Casefinding among preschool children is even more important and more difficult—more important because the child between two and

five years is at his peak in the establishment of language and speech habits and because a handicapping hearing loss must be offset as early and as thoroughly as possible; more difficult because of the nature of children and of hearing. It is not easy to interest a four-year-old sufficiently to make an accurate test of hearing thresholds, and very special clinical technics must usually be employed for younger children. Yet when a child has a recurrent ear infection, or frequent colds, or runs a course of high fever with illness, or is delayed or retarded in speech, or when a baby does not babble normally, or cannot be awakened by voice, or responds to nothing but loud noise, the question of impaired hearing should be raised and appropriate referral made.

The Role of the Nurse

Within a communitywide program the public health nurse—entrepreneur, ambassadress, and mistress-of-many-trades in the furtherance of the family's health and welfare—can do much to promote knowledge about hearing and better management of hearing problems. Her position in the preventive task is doubly important because she enters the homes and knows the problems, often in intimate detail, of the families within her community. She often cares for the mother before birth and gives guidance about infant growth and development, works in well baby clinics and in preschool roundups, acts as school nurse and factotum in routine and special clinical services. In some communities she is even expected to do screening audiometry just because she knows something about ears and children. In a well designed program she can become a major factor in public education on a personal, family basis. She can by judicious attention to a few details of infant health and development achieve much in the early detection of hearing impairment during the years when good hearing is most important in the development of language and speech. These years do not begin at school age. They lie in the period between two and five.

Interpretation

When cases are found and taken through medical diagnosis the public health nurse—again on a personal, family basis—can do much to intepret the significance of the physician's findings to the family, to follow up the child's condition to be sure that recommended medical therapy is carried out, and to check the results. As the teacher is trained to consider the whole child, so, too, must the public health nurse learn to interpret the relations among vision and hearing and behavior in terms of healthy growth and development. She must know that hearing is not a static entity related only to the physical mechanism but is very much a part of the dynamics of behavior.

Nowadays when a child suffers an attack of, say, influenzal meningitis at the age of four he usually survives, thanks to modern chemotherapy, but often at the expense of a great deal of hearing. He has some residual hearing, perhaps, but not enough to get along with. He has started to talk, but his speech rapidly becomes muddy and distorted. He has lost much more than hearing; he has lost his ability to learn language and speech normally and readily and his ability to communicate with his family.

Or, perhaps, a child has a moderate amount of nerve-type hearing loss, involving permanent damage to the inner ear, as a result of prenatal infection, injury in childbirth, or some virus disease in infancy. He is not deaf for he hears a good deal of certain intensities and pitches of sound: but he does not hear well enough to understand clearly and to learn to imitate sounds. Language and speech and social behavior in general may be severely retarded. Neither he nor anybody else in the family understands very well what is going on or why he acts as he does.

Or, perhaps, a child has a moderate amount of conductive-type impairment with a history of frequent colds and recurrent upper respiratory infections. He has had an earache a couple of times but got over it without medical attention when the tympanic membranes ruptured. He gets along fairly well in close conversation but is dull in school. He has to use a good deal of energy just to try to keep pace with what is going on.

Then, there is the child who presents no obvious symptoms, whose problems of hearing

impairment are in the incipient stage, associated with adenoid tissue in the nasopharynx and nonpatent acoustic tubes. His symptoms are subclinical by most standards, and the possibly developing problem cannot be detected except by a careful, screening, audiometric examination that furnishes useful data to the examining otologist. Children with these subclinical symptoms—and there are vast numbers of them—are not necessarily handicapped in speech-hearing and can often pass a group speech-hearing test within normal range. A pure-tone test will pick them out, however, and label them as cases to be watched with great care.

Here are four typical kinds of cases, and they may be complicated considerably as various types of lesions occur together to compose a mixed-type impairment, part of which may be remedied by adequate medical care, part of which is not amenable to treatment. These problems, centering in the ears, but with implications that involve the whole range of development and behavior, must be interpreted by the physician, the audiologist, and the nurse to the parent and the teacher. This is a fair-sized task.

Community Teamwork Needed

A great deal is known these days about both medical and nonmedical aspects of hearing impairment. What is known should be organized and put into practice on a communitywide scale. Some of the older technics of screening for casefinding are being superseded by new methods and instrumentation. Technics have been well worked out for school-age children; much more must be done with the younger children to find the problems early and start them on the way toward repair or rehabilitation. Various designs for good diagnostic work have been developed. They are probably best organized through the leadership of and in coordination with the county medical associations, so that adequate medical care is achieved and maintained. In many sections of the country a combined local committee has been organized. In it health, educative, and general lay interests work together for comprehension and apprehension of hearing problems in the community. In a few places across the country there are major audiologic centers, usually organized as part of a medical center, staffed and equipped to undertake the entire range of diagnostic, therapeutic, and rehabilitative procedures for the special problems. These are useful for referral of the serious problems for diagnosis or treatment, and serve as liaison for cases with special treatment and training needs and as a source of personnel for diagnostic work in rural communities.

The basic work of prevention, however, is done in the community through a coordinated program which brings together the several talents and interests necessary and available. Every otologist will attest to the fact that a large proportion of impairments among adults had their onset in childhood. Because of the anatomy and physiology of the nasopharynx and the middle ear a variety of upper respiratory infections may affect the hearing mechanism and, often repeated, may bring about irreversible damage to the middle ear. It is plain, however, that with present diagnostic and therapeutic technics a great deal of this gradually developing impairment can be controlled.

Thus the fundamental preventive idea—find the problems early, follow and treat them according to the symptoms presented, and control the impairment before it develops to a handicapping degree. This is a task that calls for teamwork on a communitywide basis.

Civil Defense

RADIOLOGICAL DEFENSE

Measures to be taken for radiological defense against the hazards of an atomic attack may be classified as protective, prophylactic, evasive, evaluative, reclamative, and therapeutic.

The type of radiation hazard depends on the kind of burst. In an air burst the hazard comes from prompt and delayed radiation. The prompt gamma rays, emitted during the fission process itself, are only a small part of the initial damaging radiation released. The delayed gamma radiation due to the short-lived fission products in the raging "ball of fire" is the most important. Fifty percent of the total radiation is emitted in the first second, the other 50 percent within about a minute.

In the surface or subsurface burst, whether underground or underwater, the hazard comes almost entirely from residual and induced radioactivity.

Protective measures. If advance warning of an attack is given the recommended course is to turn off water, gas, and electricity, and take refuge in the most protected part of the basement.

For individual protection loose-fitting light-colored clothing should be worn. Such clothing would reflect thermal radiation from a blast and also absorb ultra violet radiation. No practicable type of clothing will give protection against gamma and neutron radiation.

Evasive action. Evasive action is limited by the speed with which the bomb burst does its work. The major fraction of the thermal energy is delivered in less than half a second. Anyone seeing the brilliant flash of light characterizing the air burst should fall prone to the ground. This precaution reduces the radiation hazard and the chances of being hit by flying debris.

Evaluative measures. There are two evaluative problems in radiological defense. The hazards existing after a detonation must be determined and reasonable procedures must be developed for giving medical practitioners information about the radiation damage patients have sustained.

Since in air bursts the ball of fire does not touch the earth the level of *residual radioactivity* will be too low for danger. Radiation monitoring will be important only in surface, underground, or underwater bursts. Instruments measuring beta and gamma radiation will be adequate for the monitoring job since normally no alpha radiation hazard will exist without detectable hazardous amounts of beta and gamma radiation for a period up to three months. To develop a corps of skilled monitors, personnel of fire departments and fire fighting reserves should be trained in the use of radiation monitoring instruments.

Much experimental work has been done on the use of the film badge to measure exposure to radiation, but this badge is not satisfactory for field work as it requires time-consuming developing procedures. One plan for providing the physician with the facts needed to gauge the extent of radiation damage calls for tagging casualties picked up by rescue teams as to location at time of blast, degree of shelter, et cetera.

Reclamation measures. The phase of reclamation with which radiation defense is concerned is decontamination—the removal of radioactivity from equipment, areas, or structures. Decontamination will be necessary only if a bomb has burst close enough to the ground for the ball of fire to come in contact with land or water masses.

Because decontamination of large areas is dangerous to personnel and expensive the recommended course in most cases is to evacuate the population and let time be the decontaminant. Bomb-produced radioactivity decays at a rapid rate; seventeen hours after a bomb burst only one one-thousandth of the initial radioactivity would be left.

Therapeutic measures. A well organized

plan must be worked out for maximum utilization of health personnel in the event of atomic disaster. One plan calls for the establishment of operational field stations at control points on the major roads leading into the damaged area. Another line of defense within this area might be the "fire defense perimeter" beyond which every effort is made to control the conflagration. It is not feasible to plan to fight *all* fire. During the first half hour after the blast, before the conflagration develops in full, it will be possible to send in "guide rescue" teams to escort or carry the dazed or injured to the rescue perimeter control stations.

Three major concerns for the public health official are education to dispel existing confusion about atomic hazards; development of operational plans for maximum utilization of health personnel in case of disaster; provision of more training courses to give physicians and other health workers practical down-to-earth information in the field of radiation injury.

Abstracted from "Some Public Health Aspects of an Atomic Explosion" by William H. Sullivan in the January 1951 issue of *Industrial Medicine and Surgery*.

BIOLOGICAL WARFARE DEFENSE

"What You Should Know about Biological Warfare," second in a series of booklets designed to instruct the public in individual protection against special weapons, has been issued by the Federal Civil Defense Administration. The first booklet, "Survival under Atomic Attack," was released in October 1950.

The pamphlet points out that attacks against people, animals, and food crops are possible through the use of sprays carried in airplanes, through bomb explosions, or through sabotage of factory food and water or of city water mains. Biological warfare could be effective and damaging. However, it is not a secret super-weapon and there are defenses against it.

These points are highlighted in the pamphlet:

There is nothing new about biological warfare.

Our alert health safety system is the keystone of BW defense.

We must be on the lookout for new ways of spreading known diseases.

Biological agents that might be used are well known to our scientists.

Vaccines and new remedies would prevent large-scale epidemics.

Everyone should help in detecting and identifying BW attacks.

Emergency regulations must be followed closely before and after a raid.

Simple health measures can be effective BW counter-weapons.

Civil defense authorities will give special instructions about any attack.

Copies of the pamphlet may be secured for 10 cents from the U. S. Government Printing Office, Washington 25, D. C.

CIVIL DEFENSE

In this indefinite period facing all the civilized peoples of the world, civil defense takes on an enlarged meaning. Public health workers daily make their contributions to civil defense. As individuals, they have a further responsibility to learn the special skills and technics which they may need to function if a catastrophic disaster were to occur. Public health nurses all over the country are attending classes on the medical aspects of atomic emergencies. There is much new for us to learn. But we have a basis for understanding. Think how devastating the whole picture must be to nonmedical civilians!

Again public health nurses have a special responsibility, a special privilege. Because of our close contact with great numbers of people we must assume definite leadership in helping them understand what civil defense means and to prepare to take their places in the overall program. If community morale breaks down it is because community leadership failed. Now is the time for leadership. Let us be sure nursing accepts its part.

A Report of a Study of the Effect of the Termination of Metropolitan Nursing Contracts

This study was carried out by a special NOPHN *Committee of representatives of the Visiting Nurse Society of Philadelphia, the Visiting Nurse Service of New York, and the Metropolitan Life Insurance Company.*

THE ANNOUNCEMENT of the termination of the Nursing Service of the Metropolitan Life Insurance Company by January 1, 1953, has introduced problems of readjustment which present a new challenge to visiting nurse agencies.

It becomes necessary to find other ways to compensate for the loss of income of almost $1,500,000 which the MLI has been paying annually for about 750,000 nursing visits made by more than 500 affiliated nursing agencies in the United States. A significant reason for announcing the termination of the service two and one-half years in advance of the termination date was the company's desire to allow the nursing organizations sufficient time to adjust their service and to plan for necessary budget changes.

It was decided to study a sample of case records submitted to the MLI by the Visiting Nurse Society of Philadelphia and by the Visiting Nurse Service of New York for two districts. The study included a total of 1,830 cases with 8,785 visits reported to the MLI in the alternate months of February, April, and June 1950 to give effect to seasonal variations in the study period.

This sampling was of necessity limited in size and perhaps in scope but was selected to represent as nearly as possible a case-load in which varied conditions were readily reflected in the results of the study. The entire service area of Philadelphia and two widely differing districts in New York were included to give effect to these conditions.

It was the purpose of the study to determine the probable effect of the withdrawal of the MLI with respect to:

Reduction in cases and visits
Effect on number of nursing staff
Reduction in income from the Metropolitan

The method of obtaining this information was to evaluate all of the known information on each case, assume that there was no insurance company contract, and then consider whether it was likely that the case would be reported to the agency and receive the same amount of nursing care.

The evaluation of each case was made by the nurse or supervisor most familiar with the family, the patient, and the surrounding circumstances. The information entered on the case record regarding source of the call, the nature of the illness, the service given, the reason the case was dismissed, et cetera, was helpful in making this evaluation. The guide used in evaluating the cases is outlined on page 293.

When it was decided which cases were

likely to be reported in the absence of an MLI contract, they were further classified according to the probability that they would be full pay, part pay, free, health insurance or other contract cases.

The number of visits on cases that were likely to be pay or part pay was also considered to determine whether the same number might be paid for by the patient. On this basis an estimate could be made of the eventual number of pay or part pay visits.

It is acknowledged that the results of this study have the limitations inherent in any estimate of a situation in the future. These include reliance on the opinion of the nurse or supervisor in classifying the probable status of a case at a later time. Also, the lack of MLI's customary promotion of its nursing service and the decline that might naturally be expected in the reporting of calls for nursing service by company agents and district office staffs, must be considered. Nevertheless, the study provides certain helpful and rather dependable quantitative measures of the caseload that may be anticipated upon the termination of MLI contracts. Those who participated in the review of cases and in the interpretation of the results of the study were in ready agreement that, with the information available on each case and the guide for evaluating cases, it is relatively simple to classify cases according to their probable future status for the purpose of this study.

For instance, it was apparent that a seriously ill patient in need of home nursing care would be likely to come under care even though there was no MLI contract. Furthermore, if a family was in reasonably good financial circumstances and recognized the value of the service given, it would probably make payment to the nursing agency on a full pay basis. Conversely, if a case reported by the insurance company representative required little or no nursing care, and it was unlikely that the family was able to afford the cost of the nursing call, it was evident that the case would not be reported if there was no MLI contract. An instance between these extremes would be that of a postpartal patient who might welcome the instruction and guidance available from the visiting nurse and would be inclined to seek it through regular community channels but would not feel able to meet its cost so that the case would be likely to come under the care of the nursing organization as a free case.

With these explanations in mind, it will be of interest to examine Table I which contains a summary of the evaluation of MLI cases submitted by the VNS of Philadelphia and the two districts of the VNS of New York, and the composite totals for both agencies.

The figures for Philadelphia and New York showed considerable similarity in the percentage of cases and visits likely to be reported. On the other hand, there seemed to be a marked distinction between the figures of the two agencies in the evaluation of full pay and free cases and visits. This may reflect differences in judgment of those evaluating the cases for this purpose in the respective agencies, variations in the economic or social character of the population served in the two cities, or differences in the administrative policies of the two agencies with respect to the collection of fees. It is natural to expect such variations in different nursing agencies depending upon many local circumstances. This lends added interest to the comment (below) of each agency in considering its respective experience in reviewing cases and in the interpretation of figures developed from its study.

The information accumulated on the probable caseload and its pay status provided a basis for estimating the future income from these cases, the saving in nurse time, and the loss of income that might be expected. These study estimates were obtained as follows:

The estimated fee collections from MLI *policyholders* were found for the probable number of visits on these cases charged at the last cost per visit of the agency. Part pay cases were included at half the cost per visit assuming that this would approximate the total part pay collections. Further estimates were included for newborn service at fifty cents per visit as paid for by MLI and at the half rate of twenty-five cents per visit for all cases assumed to be part pay.

The sum of these estimates for Philadelphia indicated that the eventual income for cases now paid for by the insurance company would

Table 1

Analysis of Metropolitan Cases Likely to be Reported to Nursing Agencies upon Termination of Metropolitan Contracts

Item	Philadelphia			New York			Composite Total		
	Total Studied	Likely to be Reported		Total Studied	Likely to be Reported		Total Studied	Likely to be Reported	
		Number	Percent		Number	Percent		Number	Per-cent
BY SOURCE OF REPORTING									
Agents									
Cases	429	50	11.6	205	30	14.6	634	80	12.6
Visits	1184	234	19.8	625	199	31.8	1809	433	23.9
Visits per Case	2.8	4.7	—	3.0	6.6	—	2.9	5.4	—
Family									
Cases	507	346	68.2	181	118	65.2	688	464	67.4
Visits	2581	2031	78.7	1345	1106	82.2	3926	3137	79.9
Visits per Case	5.1	5.9	—	7.4	9.4	—	5.7	6.8	—
Other and Not Specified									
Cases	399	289	72.4	109	78	71.6	508	367	72.2
Visits	2469	2206	89.4	581	500	86.1	3050	2706	88.7
Visits per Case	6.2	7.6	—	5.3	6.4	—	6.0	7.4	—
Total									
Cases	1335	685	51.3	495	226	45.7	1830	911	49.8
Visits	6234	4471	71.7	2551	1805	70.8	8785	6276	71.4
Visits per Case	4.7	6.5	—	5.2	8.0	—	4.8	6.9	—
BY TYPE OF CASE									
Morbidity									
Cases	631	400	63.4	229	133	58.1	860	533	62.0
Visits	4060	3068	75.6	1760	1319	74.9	5820	4387	75.4
Visits per Case	6.4	7.7	—	7.7	9.9	—	6.8	8.2	—
Maternity									
Cases	544	193	35.5	189	64	33.9	733	257	35.1
Visits	1024	454	44.3	403	176	43.7	1427	630	44.1
Visits per Case	1.9	2.4	—	2.1	2.8	—	1.9	2.5	—
Other									
Cases	160	92	57.5	77	29	37.7	237	121	51.1
Visits	1150	949	82.5	388	310	79.9	1538	1259	81.9
Visits per Case	7.2	10.3	—	5.0	10.7	—	6.5	10.4	—
Total									
Cases	1335	685	51.3	495	226	45.7	1830	911	49.8
Visits	6234	4471	71.7	2551	1805	70.8	8785	6276	71.4
Visits per Case	4.7	6.5	—	5.2	8.0	—	4.8	6.9	—
BY PROBABLE PAY STATUS									
Full Pay									
Cases		252	18.9		31	6.3		283	15.5
Visits		1782	28.6		240	9.4		2022	23.0
Visits per Case		7.1	—		7.7	—		7.1	—
Part Pay									
Cases		180	13.5		67	13.5		247	13.5
Visits		1940	31.1		804	31.5		2744	31.2
Visits per Case		10.8	—		12.0	—		11.1	—
Free									
Cases		253	18.9		128	25.9		381	20.8
Visits		749	12.0		761	29.9		1510	17.2
Visits per Case		3.0	—		5.9	—		4.0	—
Total									
Cases	1335	685	51.3	495	226	45.7	1830	911	49.8
Visits	6234	4471	71.7	2551	1805	70.8	8785	6276	71.4
Visits per Case	4.7	6.5	—	5.2	8.0	—	4.8	6.9	—

be 45.6 percent of the amount that has been paid. For New York, where the estimate of probable pay cases and the amount of income from these cases was substantially less than in Philadelphia, it appeared that the eventual income would be 26.2 percent of present contract payments. The composite figure for both agencies is equal to 32.5 percent of the present MLI income.

The effect of the reduction of MLI *caseload* on the nursing time saved and on the operating costs of the agency was next considered. The number of visits *not* likely to be reported subsequent to the termination of the insurance company contract was used as a basis for these estimates. This visit total was adjusted to an annual basis and divided by the average number of visits per nurse year as shown by the agency's last annual cost statement. The result was equal to the visit production of 3.92 nurses for Philadelphia and 7.25 nurses for New York, a total of 11.17 nurse years for both services.

These estimates were then translated into equivalent money values on the basis of the gross cost per nurse year shown by the annual statement. While the cost per nurse year includes certain fixed overhead expenses that may not be adjustable in direct relation to staff adjustments, it affords a theoretical basis for determining the total value of a nurse to the agency. If the cost shown by this calculation cannot in fact be saved because of inflexible overhead components, it is at least possible to extend other useful services to the community without increasing the existing overhead structure.

With this in mind, the gross cost of maintaining nurses no longer assigned to give service under the MLI contract was equal to 30.8 percent of the amount payable under the contract for Philadelphia and 32.5 percent for New York, a composite of 32.0 percent for both agencies.

The loss of income from cases that would continue to receive care on a part pay or free basis was then determined at half the cost per visit for part pay cases and at the full cost for free cases. This loss of income was equal to 23.6 percent of the contract payments for Philadelphia and 41.3 percent for New York, or a composite of 35.5 percent of the amounts paid by the insurance company.

The foregoing study estimates are summarized in Table II.

It will be seen that the eventual disposition of the MLI service on the basis of the composite results of this study will be that approximately one third of the service will continue on a full and part pay basis, one third will be discontinued, and the remaining third will continue on a part pay and free case basis, payment for which will come from contributions and other contracts. The proportions may differ significantly in specific communities under varying conditions, but these study results provide a foundation for considering the general effect of the MLI withdrawal upon future program and budget needs.

If an agency is interested in obtaining a rough estimate of its own experience on a percentage basis, this may be done by a comparatively simple procedure. Percentagewise, the results obtained from this simplified method should approximate those derived from the computations in the study. The

Table II. Expected adjustments in income and service after MLI contract termination

	Percentage Distribution		
	Philadelphia	New York	Total
Estimated fee collections from MLI policyholders	45.6	26.2	32.5
Estimated reduction in MLI caseload	30.8	32.5	32.0
Income needed to maintain necessary program	23.6	41.3	35.5
Total MLI Payments	100.0	100.0	100.0

simplified procedure may be outlined as follows:

1. Select a recent month or other sample period for which the MLI case records are generally representative.

2. Using the guide (page 287), classify the visits on each MLI case according to their probable future status after termination of the contract under the following headings:

A. Full pay visits
B. Part pay visits
C. Free visits
D. Visits not likely to be made
Total MLI visits

3. Divide the number of part pay visits equally between the full pay and free visits.

4. Regroup the visits totals and compute the percentage distribution as follows:

A. + ½ of B.	= Estimated pay service	x%
C. + ½ of B.	= Estimated free service	x%
D.	= Estimated reduction in service	x%
	Total MLI service	100%

It is hoped that this study report may be helpful to other agencies in evaluating the probable disposition of their own MLI caseload, in effecting desirable staff adjustments, in considering revised budget needs, and in planning the development of new sources of income from fee collections and other means.

Comments on the Study

I Visiting Nurse Society of Philadelphia

RUTH W. HUBBARD, R.N. and
KATHRYN FRANKENFIELD, R.N.

WE BELIEVE THAT the study made within our agency has validity because of the knowledge and understanding which our supervisors and nurses have of the patients, the neighborhoods, the referring physicians, hospitals, et cetera. Since the entire agency took part, variations in judgment have not, we believe, unduly influenced the establishment of a reasonably reliable general picture for Philadelphia.

Because of the deviation shown by the figures on the probable fee collections from cases likely to be reported in New York and Philadelphia, we have re-studied this section of our report and believe our original conclusions are not oversanguine. It may be that a larger part of the insured population which has used our service is in a more favorable economic bracket than is true of the neighboring city. Other cities may have still different experiences.

The reduction of 3.92 nurses estimated for our staff would not mean an actual saving equal to the figure presented. There are certain expenses, such as executive, consultant, supervisory, clerical, office space, staff health program, public relations, library, and staff education that would to some extent continue. Rather, there would be a challenging opportunity to utilize these facilities, which may become available through the estimated reduction in caseload, for continuing other program interests of our agency and in developing new and useful services.

For several years our Community Chest has

Miss Hubbard is director and Miss Frankenfield a supervisor, Visiting Nurse Society of Philadelphia.

fostered among its member agencies a responsibility to develop all possible income-producing activities appropriately falling within an agency's function. At present we are operating upon a budget with anticipated income as follows:

Agency earned income for all services rendered	47%
Agency income from endowments and use of principal	11%
Community Chest grant	42%
	100%

We do not anticipate that we could within one year increase earnings to cover the probable 23.6% loss of MLI income shown by the study. The amount involved is under 3 percent of our total income but about 6 percent of the income from the Community Chest. It would therefore be important to have such Chest understanding and support as would enable us to demonstrate our ability to recover an appreciable portion of this income from new sources.

We have been working for several years to increase the reporting of calls on which fees may be collected by use of VNS leaflets in hospitals, banks, stores, et cetera. Through an annual review of interagency policies we are trying to strengthen health and welfare agency sources of referral. Stimulation of medical referral is also a matter of active effort. We recognize that our public relations program is an important factor and are at work on it. We believe it is our responsibility to inform all parts of the community of our availability, and realize that this has been done by the MLI in the interpretation of our service to its policyholders.

A noticeable decrease in MLI work has already become evident in our monthly billing. This fact and the likelihood that unreported cases will largely consist of those with relatively few visits should result in some saving of nursing and clerical record time.

As we view the withdrawal of the MLI in the light of NOPHN's statement "Public Health Nursing Adjustments in the National Security Program" (see page 259) we feel that we may find ourselves able to make the required adjustments on the basis of the total community and to reach those who need us most by a broad consistent program of public relations and interpretation. We have sometimes felt that we are in danger of working only to answer properly all calls received, but are failing to review them periodically to be sure that we are actually occupied with the most important work to be done. We do not mean that we are not fruitfully busy but we wonder whether other patients who have not called us may be in greater need than those we know. Perhaps this challenge will enable us to find such patients and to develop greater judgment in giving VNS care.

II Visiting Nurse Service of New York

MABEL REID

TWO DISTRICTS, Fordham and Lower West Side, were chosen for the study from the fourteen which make up the total area served by this agency in three of the five boroughs of New York City.

Fordham is a region of apartment houses and small homes, partly suburban in character, where the number of insurance patients is very large. Lower West Side is an older section of the city where the amount of insurance work is relatively small. Both districts have approximately the same population and each is served by a staff of eleven nurses, exclusive of supervisors and students.

There were 495 MLI cases included in the study, 327 in Fordham and 168 in Lower West Side.

Forty-six percent of the cases were judged likely to have come under care had there been no insurance contract, and it was estimated that 71 percent of the visits would have been made. In both districts the percentage of morbidity cases so judged was considerably higher than that of maternity and newborn cases. It would appear that only one third of the maternity and newborn cases carried on the MLI account could be expected to come under the care of visiting nurses without the insurance contract and less than half the visits to this group of patients during the period of the study would be made. On the other hand, at least two thirds of the noncommunicable morbidity cases (58 percent of all morbidity cases) would probably be referred regardless of insurance and three fourths of the visits to sick patients would be made.

With regard to the number of visits likely to have been paid for by the families in full or in part, or by some contracting agency other than the Metropolitan Life Insurance Company, Fordham and Lower West Side presented pictures that were quite different. In Fordham, the proportion of visits for which fees might be anticipated was considerably larger than it was in the Lower West Side district. In both areas, it was agreed that fee collections on morbidity visits were more promising than on visits to new mothers and babies.

In recent years we have noticed an emphasis on morbidity service. New types of treatment for chronic illnesses have been partly responsible for this trend but it has also been encouraged by income-producing contracts. At the Visiting Nurse Service of New York, contracts with hospitals to provide home nursing service in cooperation with home care transfer programs have helped to offset declining income from the MLI contract. At present, 15 percent of all VNSNY visits are being financed through such programs which are largely concerned with longterm illness. A contract has recently been signed with the Veterans Administration to provide home nursing care for veterans with service-connected disabilities. In the last few years, visits to patients receiving Old Age Assistance for which the VNSNY receives part payment from tax funds, have increased to a marked degree. As morbidity work has increased, visits to maternity patients and newborn infants have become fewer. It now appears that a higher percentage of MLI morbidity cases will probably be retained after termination of the MLI contract than will be true of the MLI maternity cases. The morbidity cases which will come under care will be those requiring more than the average number of visits per case and the maternity patients are likely to include those with complications. Relatively few of the normal postpartum-newborn cases now included on the MLI account will become VNSNY patients without the insurance company contract.

In New York City, special provision has been made for the care of premature infants and a good referral system brings most such babies under the care of the visiting nurses after their discharge from the hospital. Cooperative agreements worked out with individual hospitals provide for the referral of primiparae and other groups of maternity patients with special problems. By continuous attention to these and similar agreements and the means for implementing them, a goodly number of the MLI maternity and newborn patients most in need of nursing care will probably be reached after the termination of the MLI contract, but this type of service will need to be financed largely from contributions or endowment income.

WHILE NO TWO districts are alike, it is believed that an average district office with eleven staff nurses where, in 1950, MLI service required and supported the work of one and one-third nurses, will need only one nurse to serve MLI policyholders after the present contract ends. Fees collected from the policyholders and from other existing contractual agreements will probably provide less than half the income needed to maintain that nurse on the staff.

To summarize, it is anticipated that almost half of the MLI cases nursed during the first

half of 1950 under the MLI contract will come under nursing care in a half-year period after the termination of the contract; that approximately 70 percent of the visits to MLI policyholders will continue to be made; that the time of one nurse will be needed to serve the MLI policyholders who in 1950 required the services of one and one-third nurses; that not more than half the income required to support this amount of service can be anticipated in fees from patients or other existing contracts. Furthermore, the termination of the MLI contract will tend to weight the agency's program toward further concentration on morbidity service and reduce the proportion of service to maternity and newborn infant cases.

This study has stimulated the VNSNY to do some serious thinking about its changing program as well as about the sources of its income.

Miss Reid is statistician, Visiting Nurse Service of New York.

III Community Chest of Philadelphia and Vicinity

W. T. McCULLOUGH

THE CONSISTENCY of the results from the two sample study areas can be regarded as significant for planning purposes in respect to the proportion of present volume of MLI service which is likely to be reported after the termination of MLI contracts. It would appear, however, that the actual impact of the change on community financing of nursing services may differ from one community to another and be affected by a variety of factors, among which would be the present policies and practices with respect to fees and charges for other than MLI contract services.

The combined study results do provide a rough and ready basis for estimating the probable effects of the change due January 1, 1953, and indicate that adjustment to the change will not be so great that orderly planning by the Community Chest and the Visiting Nurse Services that begins at once and continues through the next two years cannot solve the problem. It is apparent that financial planning will need to go along hand in hand with program planning in order that the constructive community health progress enabled by the MLI contract service over the years will not be lost in the effort to "make ends meet."

Mr. McCullough is director, Agency Operations Department, Community Chest of Philadelphia and Vicinity.

Guide Used for Evaluating Cases upon Withdrawal of Metropolitan Nursing Service

Consider and weigh each of the following:

1. Source of income
2. Diagnosis
3. Service to patient
4. Family circumstances

Review information on case records and additional evaluation of nurse or supervisor. Then classify each case under the heading, "Likely to Be Reported," as Yes, No, or Doubtful. Enter additional information, such as eligibility for public assistance, other insurance benefits, et cetera, in "Remarks" column.

In considering the four items listed above it may be necessary to balance one against another. For instance,

On cases reported by MLI agents

a. A seriously ill patient in need of nursing care would have been reported to the nursing agency even if there were no MLI contract.

b. A patient not sufficiently ill to require professional nursing care would probably not have been referred to the nursing agency unless payment were to be made under an MLI contract..

c. A convalescing patient who had been seriously ill would not likely have been referred to the nursing agency in the absence of an MLI contract as the case had not been referred during the acute stage of the illness.

Consider physician- or clinic-reported cases as likely to be reported after termination of the MLI contract.

In general employer-reported cases are not likely to be reported unless a contract exists between the firm and the nursing agency.

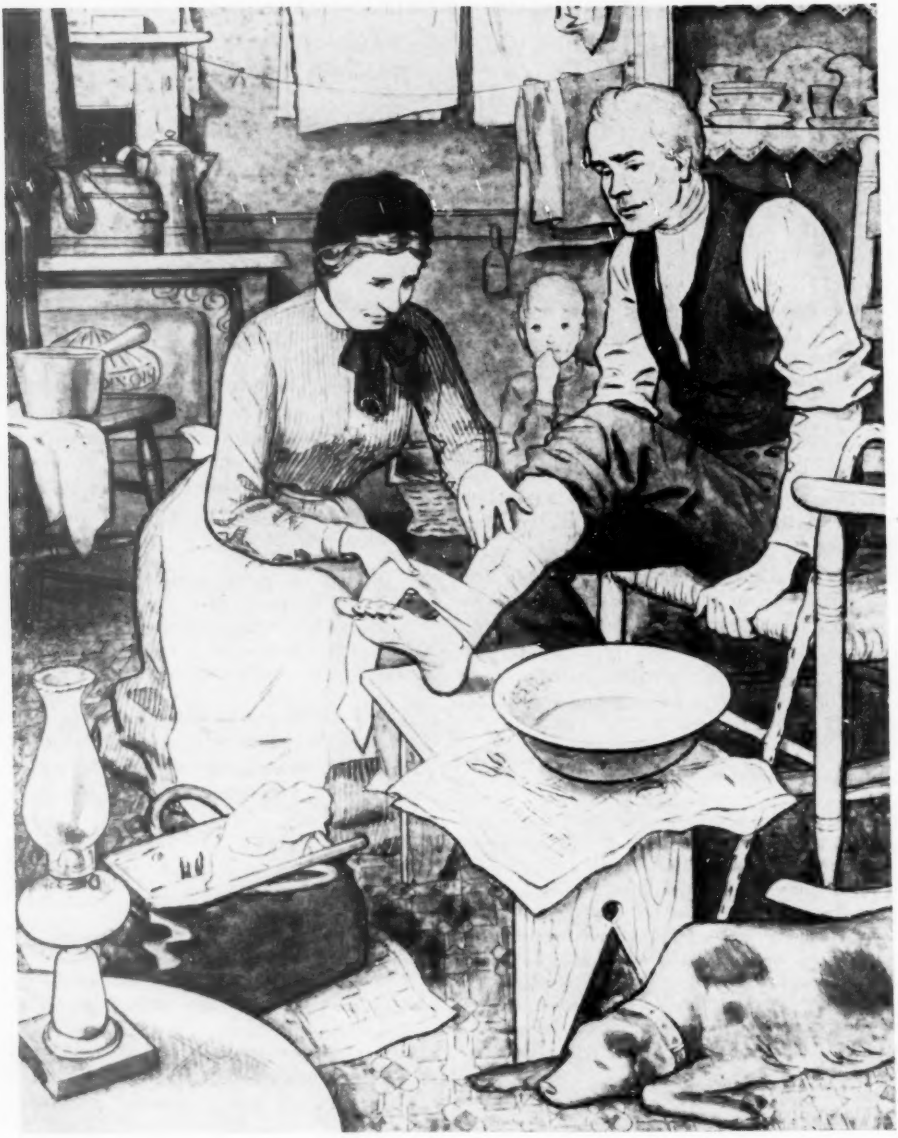
If the diagnosis and length of time sick show the patient to be chronically ill it is likely the case would be reported under the following conditions:

1. If a new treatment is ordered which cannot be administered by the family.
2. If a member of the family who has been caring for the patient becomes ill or cannot give the care temporarily for some other reason.

Patients who require highly skilled nursing service which cannot be taught to the family, such as complicated dressings, bladder irrigations, colonic irrigations, et cetera, are likely to be reported.

Patients requiring physical therapy are likely to be reported under the following conditions:

1. If it is known there is a physical therapist on the staff of the nursing agency.
2. If the family has the means to pay for the visits or if the fee can be met through some other means.
3. If the physical therapy treatments are a vital need in the rehabilitation of the patient.



THE FIRST VISITING NURSE IN BOSTON

from a painting by Paul Hawthorne

Courtesy of the First National Bank of Boston

IN MEMORIAM

"My sword I give to him that shall succeed me and my courage and skill to him that can get it—death, where is thy sting? Grave, where is thy victory,—so he crossed over and all the trumpets sounded for him on the other side."

—Pilgrim's Progress

Elin Anderson, 1950, Winnipeg, Canada. Miss Anderson was a member of the NOPHN Board of Directors at the time of her death. She was employed as a specialist, Rural Health Services, Extension Service, U. S. Department of Agriculture. All who were privileged to know Miss Anderson will always remember her bright spirit, her keen mind, and her deep interest in humanity

Hallie Austin, March 8, 1951, Denver, Colorado. Public health nurse in Jefferson County, Colorado; earlier in Gunnison County

Dr. Charles F. Bolduan, July 4, 1950, New York. Organizer and first director, Bureau of Health Education, New York City Department of Health, and a noted lecturer and writer in fields of public health and bacteriology

Ann D. Boyd, February 22, 1951, Denver, Colorado. School nurse in Denver for 20 years

Grace Coffman, August 13, 1950, Spokane, Washington. Retired in February 1950 after 21 years as director of public health nursing, Tacoma Health Department. Her contribution to the development of public health nursing in her state is a lasting one

Dr. Robert L. Dickinson, November 29, 1950. A great physician and artist but, foremost, a great humanitarian. Dr. Dickinson spent many years in making sculptures of the human body for medical and popular teaching. His models of the baby from conception to birth have been used for the education of nurses and parents. Copies of his work are now in many museums

Helen M. Fisher, 1951, Portland, Oregon. Miss Fisher was elected to the NOPHN Board of Directors last May. Her untimely death is a deep loss to us all. Throughout her professional life she was an active worker on SOPHN and SNA committees. Miss Fisher was director of public health nurses, Division of School Hygiene, City Board of Education, Portland, Oregon

Charlotte C. Fleming, January 11, 1951, New York. Supervisor, nurse midwifery service, Maternity Center Association, New York

Susan Fry, October 24, 1950, Nyack, New York. Miss Fry was a Metropolitan Life Insurance Company nurse for 24 years

Frances E. Gifford, 1950. Los Angeles City Health Department

Iva A. Godshalk, January 23, 1951, San Diego, California. Miss Godshalk was director of Nursing Service for the San Diego Chapter, American Red Cross

Catherine S. Goff, March 15, 1951, Philadelphia, Pennsylvania

Mrs. Lystra E. Gretter, February 27, 1951, Detroit, Michigan. Mrs. Gretter was a charter member of the NOPHN and one of the great "first ladies" in nursing. In 1907 she became superintendent of the Detroit VNA and continued as director until 1923. Mrs. Gretter was especially gifted in interesting people in working together to achieve a common aim. She was instrumental in establishing the program for public health nurses at the University of Michigan.

Our own NOPHN president, the present director of the Detroit VNA, Emilie G. Sargent, saw Mrs. Gretter just before her death. In this way perhaps we all had the privilege of saying "goodbye."

Mrs. Mary Lombard Haberstitch, November 13, 1949. Served in the Army Nurse Corps in World War II. Previous to her marriage she was on the staff of Tulsa County Health Department, Oklahoma

Mrs. Ann Hawkins, June 28, 1950, Danville, Virginia. Metropolitan staff nurse in Danville.

Mrs. Violet H. Hodgson, November 1, 1950, Claremont, California. Mrs. Hodgson served in France during the First World War. For many years thereafter she was associated with improving tuberculosis nursing in this country. From 1928 to 1933 she was assistant director of NOPHN and tuberculosis nursing consultant for NTA. In this dual capacity Mrs. Hodgson traveled widely, giving institutes for nurses. Her patience and understanding made her an outstanding teacher. She was director of nursing in Westchester County and later consultant in tuberculosis nursing, New York State Department of Health. Mrs. Hodgson was the author of several books on industrial nursing and tuberculosis nursing and contributed many articles to medical and nursing magazines. Her fine mind and generous spirit will long be remembered in the nursing world

Katharine Keegan, February 6, 1951, New York. On the staff of the New York City Department of Health, 1912-1937

Edith L. March, June 22, 1950, Bay Village, Ohio. Miss March was a nurse midwife and had served with the Frontier Nursing Service in Kentucky before she became a visiting nurse in Ravenna, Ohio. At the time of her death she was superintendent, Children's Sanatorium in Warrensville, Ohio

Mrs. R. B. McCune, 1950, Waterloo, Iowa. President of Waterloo VNA and general member, NOPHN.

Janet B. Merrill, February 2, 1951, Cambridge,

Massachusetts. Technical director of School of Physical Therapy, Simmons College. Miss Merrill had been long associated with the care of polio patients. Her death is a deep loss to the many nurses privileged to work with her

Margaret M. Moore, April 7, 1951, Crossnore, North Carolina. Public health nurse in Buncombe County for many years before retirement.

Josephine Newbill, November 29, 1950, St. Augustine, Florida. Miss Newbill was director of public health nursing, Galveston City Health Department (Texas) 1919-1942

Malvina Nisbet, March 24, 1951, Dunedin, Florida. Miss Nisbet had been director of public health nursing, Tennessee State Department of Health, 1924-1933, and later served on the staff of the USPHS until her retirement. She was active in forming the Tennessee SNA

Iva Renstrom, 1950. Ontario Health Department, Ontario, California

Rowena G. Richards, February 14, 1951. On the staff of the Virginia Department of Public Health since 1948

Mary M. Scott, December 6, 1950, Baxter Springs, Kansas. Maternal and child health public health nursing consultant, Kansas State Board of Health. Member of Board of Directors, Kansas SNA

Dr. William F. Snow, June 12, 1950. Founder and chairman of the board, American Social Hygiene Association. He was a valiant fighter in changing public attitudes toward venereal diseases. At the time of his death Dr. Snow was a member of the NOPHN Advisory Council

Mrs. Inez Trelstad, February 3, 1951. Mrs. Trelstad was chief of Nursing Unit, VA Regional Office, Seattle, and secretary of the Washington LNE. She had been supervisor in the Seattle VNA

Jane L. Tuttle, July 7, 1950, Columbus, Ohio. Executive director of the DNA, Columbus, 1908-1947. First woman member of Columbus Board of Health; past president, Ohio SNA; and a life member, NOPHN. Her unselfish devotion to her work inspired all who knew her.

Polio Pointers for 1951

If Polio Comes . . .

DO—Allow children to play with friends they have been with right along. Keep them away from new people, especially in the close daily living of a home.
Because—Once polio has appeared in a community scientists say the virus probably is widespread. Your children probably have come in contact with it already and developed a degree of resistance to that particular virus.

DO—Watch for signs of sickness, such as headache, fever, sore throat, upset stomach, sore muscles, stiff neck or back, extreme tiredness or nervousness, trouble in breathing or swallowing.
Because—During an outbreak of polio symptoms vary from the very vague to actual paralysis. Watch closely for all symptoms during this period.

DO—Put a sick person to bed at once, away from others, and call the doctor. Quick action may lessen crippling.
Because—While paralysis cannot be prevented doctors have determined that early bedrest and prompt treatment may influence progress of the disease and lessen the severity of deformities.

DO—Telephone your local chapter of the National Foundation for Infantile Paralysis if you need help. Locate through telephone book or health department. No patient need go without care for lack of money. Your chapter will pay what you cannot afford.
Because—The 2,800 local chapters of the National Foundation, supported by your contributions to the March of Dimes, exist for this purpose. Other March of Dimes funds are spent for scientific research and the training of much needed professional personnel.

DO—Remember, at least half of all polio patients get well without any crippling.
Because—Recent surveys show that 50 percent of all diagnosed polio cases suffer no paralysis at all. Another 25 percent recover with no disabling aftereffects. Fifteen percent are severely paralyzed and about 8 percent die.

Regional Planning for Public Health Nursing Education in New England

ANNA C. GRING, R.N.

IN THE UNITED STATES varying connotations have been ascribed to the terms region and regional. Perhaps one of the first attempts to characterize regions was in the geographic sense. As a result many of us learned geography in relation to the Piedmont region, the Eastern Coastal, the Rocky Mountain, and the Pacific regions. Sociologists use the term to describe in one word a myriad of economic, social, and cultural characteristics that give an area a unique but unified distinction. To many, regional thinking has been synonymous with provincialism. It may be noted that in recent years rugged individualism and internationalism are not usually considered graceful dancing partners. In the health field the Public Health Service of the Federal Security Agency has led the way in its establishment of regional offices. Through the state health departments these offices serve the citizens in sociological groupings which have been generally accepted.

Since nursing may be considered one of the social sciences, regionalism for purposes of planning public health nursing education can probably take its cue from sociology. In this sense the regional approach views a given society as a whole; enables all the social sciences to contribute to its study; offers a common field through which many of the present trends in social research may be applied; provides for adequate delimitation of its boundaries and extends the range of quantitative effort to discover new facts; and demands the coordination of all kinds of approaches.[1] When regionalism is thus defined, the investigator is required to see a region as a whole. On the other hand, decentralization is inherent in regionalization. The successful correlation and coordination of diverse factors focus attention on the greatest values and unique significance of regionalization.

Demonstration in the South

This sociologic concept of regionalization in educational planning has already been ably demonstrated by the South. In October 1947 the governors of the southern states, meeting at Asheville, North Carolina, decided to create an extensive program of regional action for education. Their purpose was to provide "either within the several states or without . . . adequate facilities for higher education for both whites and Negroes. . . ."[2] Following this first formal agreement to make a joint effort to meet common needs, their decision began to take tangible form. A compact was proposed in order to establish a specific basis for planning and establishing "regional educational facilities."[2]

Early in 1948 the governors signed the

Miss Gring is associate professor of nursing, Boston University School of Nursing. She prepared this article with the guidance of a reviewing committee composed of Mary C. Crowell, Marie Farrell, Mrs. Mildred Hatton, Geraldine Hiller, Theresa G. Muller, Martha Ruth Smith, and Lucy Gordon White.

[1] Odum, Howard W. *American Social Problems.* N. Y., Henry Holt, 1945.

[2] Ivey, John I., Jr., and William J. McGlothlin. The South's evolving pattern of regional planning in higher education. *Higher Education,* January 1, 1950, v. VI, p. 100.

compact and agreed to submit it to their respective legislatures for approval. Pending legislative approval the Regional Council for Education, which included the governor and two members from each of the fourteen states, was incorporated and set up in Atlanta in September 1948. Since every type of professional education is not offered within every state provision had to be made for the flow of students from one state to another. After study, the Council decided that medicine, dentistry, and veterinary medicine had priority in planning. It worked out a basis for contracts with various institutions and a minimum program, including a minimum budget. Within a comparatively short time the legislatures met and approved the budgetary request, implementing their approval with funds. With the approval of the first ten states the Regional Council for Education was superseded by the Board of Control for Southern Regional Education in January 1949. At the present time contracts are made between states and institutions with the headquarters of the Board of Control acting as the contracting agency. The overall plan is that the state pays the contracting institution a flat sum per year per student for the indicated professional education, and the student pays the institution the usual expenses but escapes the burden of out-of-state fees. Approximately forty contracts have been signed between the board, the states, and the appropriate institutions.

This arrangement provides for more efficient use of existing facilities; more effective utilization of instructional personnel; improved curriculum offerings available to a wider range of able students at low cost; and greater returns on the funds invested in terms of ultimate social benefits. Some types of programs, such as medical education, can be operated more effectively at less cost if they serve a larger group of students than would in many cases be enrolled at any one time in an institution serving a single state in this region. Under this plan one state may share its strong facilities and programs with other states, and in turn secure for its residents training opportunities which it cannot provide economically and effectively. Thus unnecessary duplication of costly facilities is avoided. The specially qualified faculties essential for these special programs are concentrated in fewer centers, insuring better quality of instruction. The funds saved in reduced operational costs may then be diverted to strengthening programs and faculties.

New England Planning for Public Health Nursing Education

How does the New England Regional Planning Committee for Public Health Nursing Education meet the criteria described in the sociological definition of regionalization? Nursing representation is broad, as is illustrated by the current membership of the committee, which includes state directors and/or educational directors of public health nursing in the six New England states; the directors or educational directors from the visiting nurse associations of Boston and Worcester, Massachusetts; Concord, New Hampshire; Hartford and New Haven, Connecticut; and Providence, Rhode Island. The following colleges and universities participate in this regional planning committee: Boston College, Boston University, Harvard School of Public Health, Simmons College, University of Connecticut, University of Vermont, and Yale University. The committee has been fortunate in that consultants from the National Organization for Public Health Nursing, the U. S. Children's Bureau, and the U. S. Public Health Service have participated in all meetings. Lay representation is more limited than desirable; Rhode Island, Massachusetts, and Connecticut are the only states that have recommended lay participants. There has been no attempt to include representation from related fields, some of which are known to have similar problems.

Both at the preliminary conference in February 1947 and in succeeding meetings consideration has been given to both the nursing needs and field resources of the region as a whole. Frequent references have been made to the economic framework, although no attempt has been made actually to study New England from the broader sociological viewpoint. Sincere and increasingly effective efforts are being made to correlate and coordin-

ate the public health nursing field resources, known and potential, with the known and anticipated needs of students, agencies, universities, and, last but by no means least, with the resources and needs of the general public.

The beginnings

In 1946 the Boston University School of Nursing was organized as an independent professional school in order to help meet current needs in New England by offering several types of professional nursing education not then available in the region. The programs which were started were of two main types: those for graduate nurses leading to a Bachelor of Science or Master of Science degree in nursing or nursing education, with minors in maternity, medical, orthopedic, pediatric, psychiatric, and surgical nursing; and the four-and-one-half-year basic professional program for qualified high school graduates leading to a Bachelor of Science degree with a major in nursing.

A generous grant from the W. K. Kellogg Foundation enabled the university to participate in the foundation's postwar nursing program and at the same time provided for more extensive professional education for graduate nurses. As part of this plan a sum of money was set aside to bring together a representative group of nurses concerned with public health nursing service and education to determine whether Boston University School of Nursing should include public health nursing education for graduate nurses in its educational program, or whether its intent to include public health nursing in the basic professional program was the limit to which public health nursing education should be provided in the university's newly established school. Accordingly, in February 1947, under the aegis of Boston University School of Nursing and the leadership of Dean Martha Ruth Smith, a conference was held to discuss the public health nursing needs in New England from the standpoint of the educational needs of the nurses, the opportunities and facilities available for their education, and finally to consider the future place of Boston University School of Nursing in the field of public health nursing. Mrs. Leah Blaisdell Bryan was chairman and Mary Connor co-chairman of the meeting.

After due deliberation the group recommended that an all-New England committee for planning public health nursing education be formed. There was general agreement that public health nursing personnel should be added to the faculty of Boston University School of Nursing to develop a program for the preparation of public health nursing supervisors and to implement the efforts of the Planning Committee for Public Health Nursing Education.

Creation of New England planning committee and new university program

Following this preliminary meeting the W. K. Kellogg Foundation demonstrated its confidence in the committee's recommendations by providing money for an experimental period to initiate both the Public Health Nursing Department in the Boston University School of Nursing and the New England Regional Planning Committee for Public Health Nursing Education. The latter represented the first identifiable effort of the Kellogg Foundation in regional planning for nursing education within the period of their postwar nursing project (1945-1949). The Public Health Nursing Department was initiated in September 1948. The first meeting of the reorganized New England Regional Planning Committee was held in December 1948 at Boston University School of Nursing. Two days were devoted to a discussion of the problems concerned with the utilization of known field resources and the finding and development of new potential areas. The functions of this New England Planning Committee were also discussed. Implicit in the discussion was the recognition of the importance of adequate field resources. There was general agreement that the committee should focus its attention on developing reciprocal arrangements between universities and field agencies and should participate in curriculum construction.

At the next meeting of the committee held in April 1949 Dean Martha R. Smith was elected chairman, and the Public Health Nursing Department of Boston University School of Nursing assumed responsibility for

preparing reports of the sessions. Membership on the committee was broadened to include representatives from the seven New England universities and colleges, the six New England state directors of public health nursing, the directors or educational directors of six local voluntary public health nursing agencies (to be selected because of their known interest in university affiliations) and six lay representatives, one to be recommended by each of the state directors of public health nursing.

Work groups started

At the April 1949 meeting the committee organized itself into small working groups to consider these problems: the agency-university agreement form, the objectives and desired outcomes of student public health nursing field experience, potential and known field resources for providing essential public health nursing field experience suitable for meeting diverse student needs, and student evaluation. Following the group meetings the overall committee met to report progress and recommend interim procedure.

This same pattern has prevailed at all the succeeding meetings of the committee, with the exception that occasionally special luncheon speakers were invited to discuss other experiences in regionalization and ways of improving nursing service. Guests included Dr. Daniel Marsh, chancellor of Boston University; Dr. Brooks Ryder, administrator of Bingham Associates Program; Dean Margaret Bridgman, consultant in collegiate education, Russell Sage Foundation; Mildred Tuttle, nursing director, W. K. Kellogg Foundation; Irene Carn, associate chairman, Skidmore College Department of Nursing; and Anna Fillmore, general director of the National Organization for Public Health Nursing.

At the meeting held in November of the same year a group feeling, or a feeling of oneness, seemed evident, if such comments as "I think we're making progress," and "We should have more frequent meetings," are any criteria of group solidarity. At this time the members of the overall committee elected to join the working group concerned with the problem of their major interest. Each working group included representatives from both official and nonofficial agencies and universities. The lay representatives were primarily concerned with agency-university arrangements. There was some floating from group to group. It was practically impossible to secure complete continuity at successive meetings because of unavoidable absences, change of personnel, and the time lapse between meetings.

Gradually, however, matters of individual agency and university concern are becoming identified and accepted as area problems, and an increasingly objective and realistic approach seems evident. In realization of the common need for a unified approach to preparation of nurses for public health nursing positions there is an obvious movement toward the curriculum committee. The result is that all committees and subcommittees wish to meet with the curriculum committee at the next scheduled meeting.

To date six two-day conferences have been held in Boston, which has been selected because of its convenience for the majority of the members and the consequent reduction in both travel time and expense. Part of the agenda of the afternoon session of the second day of every conference is devoted to the selection of the date and place of the next meeting. Simmons College was hostess for the April 1950 meeting and Boston College for the October 1950 sessions. The next meeting will be held at the Harvard School of Public Health.

Accomplishments of the Committee

The accomplishments of the Regional Planning Committee may be summarized in relation to each problem studied. An agency-university agreement form was accepted and is being used currently by one state agency, four nonofficial agencies, and one university. (See page 303.)

Field resources

The field resources work group made a survey of the public health nursing resources in New England. Although it failed to reveal new potential resources the survey brought out such problems as the need for

cars for students assigned to rural areas and the necessity for centralized allocation of students for wiser use of existing resources. It also focused attention on the many one-nurse services in New England whose nurses recognize that their situation is inadequate for student affiliations at the present time.

Student evaluation

The study group concerned with student evaluation prepared a tentative form for agency use. Following a field trial spin the group agreed that evaluation of student progress should be made by an experienced supervisor whenever possible. In the event that an inexperienced supervisor is responsible for student evaluation she should be guided by an experienced person. In other words, a guide for the use of a form, however detailed, is not a substitute for qualified nursing supervision. The anecdotal record is preferred as a tool for the analysis and appraisal of the student's capacity. An evaluation should give a picture of the nurse as a person in relation not only to her professional adjustment but also to her competence in the particular block of experience which is being appraised. The group agreed that a form which is designed for checking gradations of competence in many categories often fails to give a total picture of performance. They expressed the need for a guide which would be more inclusive and allow greater flexibility than most "check" forms.

Criteria for selecting families

The functions of the work group concerned with evaluation were expanded to include study of the student's total experience, relating it to specific areas and to the desired outcomes of field experience. Criteria were formulated for the selection of families for student experience. It was agreed that families should be selected in which the nurse may hope to meet with some degree of success and in which she may have an opportunity to give continued health supervision. Some of the families chosen should be composed of different age groups receiving a variety of public health nursing services. It is also desirable that the student should have experience in families representing a variety of socioeconomic and racial patterns. Opportunity should also be provided during the experience to permit the student to participate in family planning with other community agencies and with other members of the health team within the service agency in which she is gaining experience.

Curriculum committee started

The work group concerned with the objectives and desired outcomes of field experience drew up criteria to be applied to the six weeks to eight weeks experience for graduate nurses preparing for public health nursing positions. The report was accepted by the committee and this work group then became the nucleus for the curriculum committee which was formed at the November 1949 meeting.

The evolutionary process characteristic of the overall New England committee is probably most clearly illustrated in the work of the curriculum committee. Both agency and university problems were presented at the first meeting. This resulted in a compilation of the collegiate programs in New England in which the stated objectives include the preparation of students for public health nursing positions. There are fourteen universities and colleges offering a basic nursing program of which thirteen are on the bachelor's level and one the master's level. There are four programs preparing graduate nurses for public health nursing positions.

Recommendations for collegiate basic programs

A survey of the range of hours devoted to certain subject areas in the New England collegiate basic programs failed to show a correlation with the future needs of the student. For instance, five colleges do not offer nutrition; four colleges do not offer methods of teaching; eight colleges do not include child growth and development. The committee therefore recommended that efforts be made to include the following areas in the collegiate basic program: nutrition, particularly as it applies to family situations; interviewing technics; increased practice in nursing skills; appreciation of problems of geriatrics; active

participation in the referral of individuals for continuity of care; human growth and development; principles of epidemiology; principles and methods of teaching and opportunity for practice; appreciation and realization of the value of biostatistics; practice in the communicative skills; and cultural courses.

The committee has given considerable thought to the new university programs which are in the early experimental phase and which have been designed to prepare graduate nurses for staff positions in hospitals and public health agencies. As a result, a subcommittee was appointed to write to the NOPHN Education Committee suggesting that early consideration be given to establishing criteria for evaluating these programs.

University programs

It will be recalled that the original purpose of the first conference of this New England committee held in February 1947 was to indicate the desirability of including preparation for public health nursing in the curriculum of the Boston University School of Nursing. The committee's recommendation for the addition of a public health nursing department was based on the recognized need for a program aimed at the preparation of public health nurses for supervisory positions. The Public Health Nursing Department now includes three people, one of whom is primarily concerned with the basic professional nursing program and two with overall planning for public health nursing education in both the graduate and undergraduate areas.

A general nursing program which will be described in a later issue of PUBLIC HEALTH NURSING has been started, as has a program on the bachelor's level for senior advisers and assistant supervisors. A program in supervision and administration in public health nursing on the master's level will be started in 1951-1952. The two last-mentioned programs are the direct results of the New England committee's recommendations.

Curriculum planning

Increasingly the New England Regional Committee has become concerned with the broader aspects of curriculum planning. Subcommittees of the curriculum committee were appointed at the last meeting to analyze curriculum content of the collegiate basic programs in New England and to make an activity analysis of the preparation of field teachers, staff nurses, and supervisors. The committee as a whole then plans to consider curriculum implications based on the subcommittee findings.

The work group concerned with student evaluation is attempting to develop criteria which may be used to measure competence in relation to the gradations of preparation and experience of the public health nurse practitioner. The group concerned with agency-university relations dissolved itself at the last meeting, since its functions duplicate those of the field resource work group. The latter group is continuing its study of plans for centralized selective assignment of students to field experience.

Looking to the Future

Recurrently discussions focused on such questions as "How can we plan to continue as a regional planning group?" . . . "How can we use our combined agency and university resources to better advantage?" . . . "How may we participate in curriculum construction and thereby narrow the gap between the university and agency practice?" Inasmuch as this is the final year of the W. K. Kellogg Foundation postwar nursing project, everyone is charged with individual responsibility to think, devise, and be prepared to offer suggestions for the next steps. In October 1950 a steering committee was appointed to bring concrete plans to the next meeting for the further development of regional planning for public health nursing education in New England, thereby extending and expanding the original purpose of the parent committee.

There is unanimous agreement that the financial support of the W. K. Kellogg Foundation was the cohesive element which provided the impetus for regional planning and successfully brought together the entire group at regular stated times. This financial aid parallels the contributions of the individual members of the committee and the employing agencies who so freely gave both time and

effort not only at the semiannual meetings but also in their interim activities. Another by-product of the committee's thinking is that regional planning should be concerned with the problems of nursing education as a whole, instead of with one segment of nursing education. It has been impossible to enlarge the scope of the present New England Regional Planning Committee for Public Health Nursing Education because the stated purpose is implicit in the name of the committee and funds were so allocated.

It may be said without reservation that this committee concerned with planning for public health nursing education in New England has functioned successfully. This four-year project has highlighted the value of planning together and sharing viewpoints, both similar and dissimilar. It has succeeded in stretching our minds beyond the scope of our individual needs and problems. We hope to extend its scope and representation to provide for consideration of the broader implications inherent in providing improved nursing service to the American public. The need for more extensive citizen participation has been expressed frequently and references have been made as to the desirability of securing participation from related professional groups, such as general education, sociology, and social work.

Today we wonder if the time has arrived for the New England committee to take the initiative in exploring avenues whereby this committee can become a vital part of the New England Governors' Conference, since the conference is concerned with the total needs of the people of New England and with more efficient use of its many human and natural resources.

Agreement for Supervised Public Health Nursing Affiliation for Public Health Nursing Students of ..... University ..... with the Visiting Nurse Association of .....

Admission

The number of students and dates of admission will be regulated by agreement between the School of Nursing and the Visiting Nurse Association.

Students will be admitted for ——— weeks field experience.

Students are to be full time at the Agency and not expected to attend University classes during the day.

Credentials

Credentials shall be submitted by the School of Nursing to the Visiting Nurse Association at least thirty days prior to admission to the field.

Name of student
Date of birth
Name, address, and telephone number of person to be notified in case of emergency
Educational background
Courses completed
Record as a student
General evaluation—special strengths and needs.

Health

Each student will be required to have:

1. A complete physical examination including a chest x-ray within three (3) months prior to the beginning of the affiliation.
2. Successful vaccination against smallpox within two years of the beginning of affiliation with the Agency.
3. A negative Schick test or diphtheria immunization within two years of the beginning of the affiliation.

Report of the examination is to be sent to the Director of the Visiting Nurse Association at least two weeks prior to date of the affiliation and should contain, in addition to the above reports, a statement of specific conditions, such as an exposure to German measles.

The student will be given individual consideration when time is lost because of illness or any other reason during the period of the affiliation. It is assumed that if the student has not had an oppor-

tunity to participate in the planned educational experience it may be necessary to extend the affiliation.

The student is responsible for reporting illness to the Educational Director, who will report the illness to the School of Nursing. The student is responsible for securing medical care from a recognized physician. In the event of an emergency in which it is impossible to consult with the University the student's family should be notified.

Orientation Conference

The School of Nursing will be responsible for the orientation conference before the students begin their public health nursing field assignment. The School of Nursing and the Visiting Nurse Association are jointly responsible for the final evaluation conference.

The Visiting Nurse Association will submit to the School of Nursing an outline for the affiliation, which will be adjusted to the individual student's needs and assets.

Uniform

Regulation NOPHN uniform and overseas cap, navy blue or black untrimmed coat, and brown or black leather oxfords are required for affiliating students. Provision should be made for protection against inclement weather.

Hours

The hours of duty shall be from —— a.m. to —— p.m. from Monday through Friday.

Lunch time—one hour.

Transportation

The nurse shall furnish her own transportation to the Agency office and to her own home. Carfares used in the field shall be paid by the Visiting Nurse Association.

Living Arrangements

The Visiting Nurse Association will assist students in finding satisfactory living accommodations. The student is responsible for providing her own maintenance.

Withdrawal from the Field

The Visiting Nurse Association has the right to request withdrawal from the Agency of any student who is not able to make adjustment to the field.

Reports

Upon the completion of the student's affiliation the Visiting Nurse Association will send to the Chairman of the Public Health Nursing Department of the School of Nursing an evaluation of the student's work with rating, and a record of the student's experience.

Tuition

The fee for field experience will be at the rate of two thirds of the student's tuition fee, based on the amount of University credit given for the course. The same amount shall be paid if that affiliation is terminated prior to the end of the stipulated period.

The Visiting Nurse Association will send the School of Nursing a bill within the month following the completion of field assignment.

Termination of Agreement

Either organization may discontinue the affiliation by giving one year's notice.

Signed: _____

_____

Dean _____ *University* _____

Signed: _____

_____

President, Board of Directors
Visiting Nurse Association _____

Signed: _____

_____

Chairman, Department of Public Health Nursing
_____ *University* _____

Signed: _____

_____

Executive Director
Visiting Nurse Association of _____

Date: _____

Mental Hygiene and Growth Development

(Continued from page 251)

of the life span as a cycle of growth and change common to all, many problems that would otherwise seem unrelated now take their place as part of a pattern. Familiarity with this pattern and its significance enables the nurse to understand the needs of the individual at different periods of the cycle and to help him or his family meet these needs in a manner which promotes the mental health of the individual and those around him.

New Books
And Other Publications

THE COMMUNITY AND PUBLIC HEALTH NURSING

Edith Wensley, New York, Macmillan Company, 1950. 250 p. $3.50.

This is the fourth and last in the series of comments on Mrs. Wensley's book.

Mrs. Wensley's book will be a valuable text and handbook for student nurses, public health nurses, and nursing board or committee members. It gives a clear outline of the role of the public health nurse in her various capacities and in relationship to other public health workers and community groups. It is also well organized and interestingly written, though occasionally repetitious.

In most communities where they exist voluntary nursing agencies have been more completely accepted than their sister "official" public health nursing groups. Although it is doubtful that an "advisory" citizens committee in a governmental agency can accomplish quite so much as an administrative board in a voluntary agency, still the citizens committee can be a real aid to community interest and support. Committee members and health department personnel, however, must understand how to develop the advisory committees' full potentialities. Mrs. Wensley presents an important part of the formula by which this can be achieved.

Although the title might not indicate it the book contains many worthwhile lessons for all public health workers such as health officers, sanitarians, and board of health members. There are many pointers on how to give the people a real opportunity to take an active part in shaping their community's official health programs.

Certainly health officers might well take some guidance from the public health nurses, since we are all searching for ways to get closer to the people. This is particularly true in these days when the local tax dollars are scarce, and when we must compete for them with many groups that have learned to develop community support better than public health has.

—C. Howe Eller, M.D., Dr.P.H., *Director of Health, Louisville and Jefferson County Board of Health, Kentucky.*

MEAL PLANNING WITH EXCHANGE LISTS

Booklet prepared by American Diabetes Association and the American Dietetic Association in cooperation with the Diabetes Branch, Public Health Service, Federal Security Agency. 1950. 19 p. May be purchased from Health Publications Institute, Inc., Raleigh, North Carolina. Booklet 10c; discount on quantity orders. Diet card 5c; discount on quantity orders. One free copy of material may be obtained from Diabetes Branch, U. S. Public Health Service, FSA, Washington 25, D.C.

This booklet of special interest to public health nurses has recently been released by committees of the above organizations. It was prepared as a guide for the person with diabetes to help him select a variety of foods for his meals. There are six groups of foods—"exchange lists"—arranged in the booklet according to their carbohydrate, protein, or fat content. The six lists are milk exchanges, vegetable exchanges, fruit exchanges, bread exchanges, meat exchanges, and fat exchanges.

A particular advantage of the exchange list is that each serving on a list is so adjusted that a person may make a choice of foods without referring to a complicated food table. That is, a patient allowed three bread exchanges for a meal consults the bread exchange list on which he finds many foods which he may substitute for bread. He sees, for example, that in place of three slices of bread he may choose three other "exchanges" to get the same carbohydrate value. He may use one-half cup rice, one-third cup corn, and five saltines.

There are several other features which increase the usefulness of the booklet. Simple,

easily understood language is used throughout. Illustrations of foods on the various lists serve to lend interest and to make the materials easy to understand. Food portions are given in household measures rather than gram weights. One section of the booklet contains several recipes. The recipes give examples of how the diabetic may combine the foods that he is allowed. Each recipe clearly shows the amount and type of food to be used in its preparation with a statement of the foods to be left off when the recipe is used. Although the meal planning booklet shows food exchanges in detail it does not show the total amount of food to be eaten daily by the diabetic. A blank page is provided on which the patient's diet as prescribed by the physician may be written.

The meal planning booklet is only one of the eight parts of diet material provided for use in teaching nutrition to the patient with diabetes. To assist the physician the authors of this material have also prepared six sample meal plans. These six sample meal plans are arranged at different caloric levels, with the kind and amount of food to use for a day, and may be used by the physician in working out a diet with the patient. Sample menus are included as a part of these meal plans to illustrate ways in which the food exchange lists may be used to add variety to meals.

The eighth piece of material is entitled Diabetic Diet Card for Physicians. The exchange lists, food values, and sample diabetic diet prescriptions are summarized on this card. Gram weights for foods are also included. The diabetic diet card is provided as a reference for use by the physician, nurse, and dietitian in their work with diabetics.

These materials would be particularly useful to public health nurses in facilitating the interpretation of the principles of good nutrition for diabetics and their families. A word of caution is necessary: that the *approval of the attending physicians be obtained* before using the meal planning booklet with their patients.

—K. Barbara Dormin, R.N., *Diabetes Branch, Division of Chronic Disease, U. S. Public Health Service.*

NUTRITION

Two booklets distributed by the National Dairy Council, 111 North Canal Street, Chicago 6. Single copies available without charge.

Nutrition for Every Day Use, a Handbook of Teaching Aids. Interprets and organizes nutrition information into highly usable form. The booklet carries the seal of acceptance of the Council on Foods and Nutrition of the American Medical Association.

Safe Milk. A resumé of present information on safe milk and its importance to public health, stressing pasteurization.

GENERAL

Radiation Monitoring in Atomic Defense. Dwight E. Gray and John H. Martens. New York, D. Van Nostrand Company, 1951. 120 p. $2.

Psychosomatic and Suggestion Therapy in Dentistry. Jacob Stolzenberg. New York, Philosophical Library, 1950. 152 p. $3.75.

Physiological Hygiene. Cleveland Pendleton Hickman. New York, Prentice-Hall. Third edition, 1950. 557 p. $5.15.

NURSING

History and Trends of Professional Nursing. Deborah MacLurg Jensen. St. Louis, C. V. Mosby Company. 2nd edition. 1950. 365 p. $3.25.

NURSING EDUCATION

Regional Planning for Nursing and Nursing Education. Report of work conference held by Division of Nursing Education, Teachers College, Columbia University, 1950. New York, Teachers College Bureau of Publications. 1950. 69 p. $1.25.

Practical Nursing Curriculum. Suggestions for developing a program of instruction based upon the analysis of the practical nurse occupation carried out by the Division of Vocational Education, U. S. Office of Education, in cooperation with interested national committees. For sale by the Superintendent of Documents, Washington 25, D. C. 1950. 140 p. 65c.

(Continued on page A10)

FROM NOPHN HEADQUARTERS

STAFF NEWS

The nurse members of the NOPHN headquarters staff have just completed a course of instruction in nursing in an atomic emergency. Hedwig Cohen taught the classes. She was one of the group of local nurses who prepared the "Course outline for Nurse Instructors" approved by the Medical Emergency Division, Office of Civil Defense, City of New York. Our teacher reports the biggest problem she faced was to collect her students on Tuesday evenings, as the NOPHN field schedule offered stiff competition to our study nights. But we had several "make-up classes" for absentees and we all finished with flying colors!

JANE JORDAN ROGERS, who has recently joined our staff as assistant director for publicity, was born in Kenosha, Wisconsin, and received her education at Hathaway Brown School, Cleveland; Choate School, Boston; and the University of Arizona at Tucson. Before coming to NOPHN Mrs. Rogers did promotional work for the National Association of Manufacturers. During World War II she held public relations and executive positions with the Office of Price Administration in Washington and the U. S. Army Quartermaster.

100% NOPHN MEMBERSHIP

All members of nursing staffs in the agencies listed below have been enrolled as 1951 members of the NOPHN since the April listing was published.

What about *your* agency? If all nurses on the staff and/or all members of your board or citizens committee are enrolled for 1951 please let us know. If all have not yet joined for 1951 please remind them that their active interest and support are urgently needed if NOPHN is to get this year's big job done.

CALIFORNIA
Santa Monica Visiting Nurse Asosciation
CONNECTICUT
Madison Public Health Nursing Association
Middletown District Nurse Association
GEORGIA
Savannah—Mary Maclean Milk Depot and Visiting Nurse Association
KANSAS
Kansas City Visiting Nurse Association
MASSACHUSETTS
Duxbury Nurse Association
MICHIGAN
Bay City—Public Health Nursing Service of the Civic League and City of Bay City
NEW JERSEY
Hackensack—Central Bergen Visiting Nurse Service
Salem—Child Welfare and Visiting Nurse Association
PENNSYLVANIA
Jenkintown—Old York Road Public Health Nursing Center
Lebanon—Visiting Nurse Association

NEW MEMBER AGENCIES

We are glad to announce that the following agencies were granted membership in the NOPHN at a meeting of the Eligibility Committee held on March 2:

Clinton Public Health Nursing Association, Clinton, Conn.
Visiting Nurse Association of Metropolitan Atlanta, Atlanta, Ga.
Mount Desert Public Health Nursing Association, Northeast Harbor, Me.
The District Nurses of the Woman's Friend Society, Salem, Mass.
Community Service Society, Bound Brook, N. J
Public Health Nursing Association of Rumson, Seabright and Fairhaven, Rumson, N. J.
Visiting Nurse Association of Summit and Vicinity, Summit, N. J.
Visiting Nurse Association, Niagara Falls, N. Y.

BIBLIOGRAPHY ON FIELD INSTRUCTION

A Bibliography on Field Instruction in Public Health Nursing, prepared by the NOPHN Committee on Field Instruction, is available from the NOPHN. This is the first time NOPHN has offered for general distribution a bibliography on field instruction. The bibliography was developed in response to many

requests for such material. It will be useful to institutions conducting educational programs in nursing and to public health nursing services providing field instruction in public health nursing. The price is 15 cents a copy.

NOPHN FIELD SCHEDULE

The following staff members attended one or both of the Regional Conferences held in Omaha, Nebraska; and Providence, Rhode Island, in April: Anna Fillmore, Marjorie L. Adams, Lillian Christensen, Helen V. Connors, M. Olwen Davies, Ruth Fisher, Jane J. Rogers, Dorothy Rusby, Jean South, Elizabeth C. Stobo, Marie Swanson, Judith E. Wallin.

Other Field Trips

Marjorie L. Adams	Chicopee, Mass. Suffield, Conn. Winsted, Conn. Hartford, Conn. Litchfield, Conn. Atlanta, Ga. Daytona Beach, Fla.
Mary Elizabeth Bauhan	Boston, Mass.
M. Olwen Davies	Boston, Mass.
Helen Snow	California
Jean South	Washington, D. C.
Marie Swanson	Morristown, N. J.
Judith E. Wallin	Tulsa, Okla. Fort Worth, Tex.

ABOUT PEOPLE YOU KNOW

Margaret S. Taylor, chairman of the NOPHN Education Committee and a member of the NOPHN Board of Directors, has been granted a WHO scholarship to study nursing in Brazil, Chile, and Colombia during the summer months. . . . *Janet Campbell Thompson* has been appointed educational director in the Bureau of Nursing Services, Cincinnati Department of Health. Miss Thompson is also assistant professor of nursing and health, College of Nursing and Health, University of Cincinnati. She is in charge of the portion of the college's basic public health program which students obtain with the Cincinnati Health Department.

Helen Bouck, formerly a staff nurse with the Ulster County (N. Y.) Health Department, returns to the agency as supervising nurse. During her absence Miss Bouck secured her M.P.H. from the University of Michigan and had additional training with the Nassau County (N. Y.) Health Department. . . . The American Hospital Association announces the appointment of *Dr. Malcolm T. MacEachern* as director of professional relations. Dr. MacEachern retired recently as director of the American College of Surgeons.

M. Elizabeth Pickens has been appointed assistant director of the Bureau of Public Health Nursing, Baltimore City Health Department. Miss Pickens previously was an instructor at the Institute for the Study of Venereal Diseases in Philadelphia. In 1947 she was assistant chief nurse in the public health and welfare branch of the U. S. Army General Headquarters in Japan. . . . *Frances Crouch* has been appointed deputy administrator of American Red Cross Nursing Services. Miss Crouch served most recently as director of nursing services in the ARC Eastern area office. She holds a reserve commission as lieutenant colonel in the Army Nurse Corps.

American Journal of Nursing for May

Radiation Effects of an Atomic Bomb on Water, Food, and Milk . . . George W. Moore

The Frightened Child . . . Ruth Frank, R.N.

Surgery and the Psychiatric Patient . . . Rita McGowan, R.N.

Cancer of the Skin . . . R. Lee Clark, M.D., and Charles J. Maisel

Training Programs for Practical Nurses . . . Amy E. Viglione, R.N.

They Like Rural Nursing

The Industrial Nurse Is a Good Investment . . . Heide L. Hendriksen, R.N.

A Progress Report on Nurses' Assistants . . . Mildred Lorentz, R.N.

Preparation of the Nurse for the Psychiatric Team . . . Dorothy Mereness, R.N.

NEWS AND VIEWS

ARMED SERVICES WILL USE ANA PLACEMENT SERVICE DATA

The Army, Navy, and Air Force Nurse Corps have agreed to accept biographies from the ANA Professional Counseling and Placement Service files, when available, as part of the application from nurses for commissions in the Armed Services.

By utilizing already existing PC&PS records the processing of applications for appointments to the Armed Services should be facilitated. Also, because of the complete nature of the PC&PS records this arrangement should assist in making the best possible placement of nurses in positions for which they are properly qualified by education, experience, and aptitude.

Release of PC&PS records to the Armed Services Nurse Corps will only be done at the request of the individual nurse. The nurse should request the counselor of the Counseling and Placement Service where her credentials are on file to send them to the appropriate nurse corps officer.

Any nurse whose records are not on file or not up to date with PC&PS may obtain proper forms from her state nurses' association.

REGULATION OF RESTAURANTS

A recent Pennsylvania Supreme Court decision upholding the right of a local health department to safeguard public health by regulating the operation of restaurants may have nationwide implications, according to the Public Health Service, FSA. The decision reversed a decree of a lower court forbidding the Pittsburgh health department to grade local restaurants according to sanitation standards equivalent to those in the PHS's recommended ordinance and code regulating eating and drinking establishments.

"The Pennsylvania decision may well encourage municipalities throughout the country to grade restaurants on the basis of compliance with sanitation standards and to post the grade in the establishment where it is clearly visible to customers," declared C. H. Atkins, chief of the PHS Division of Sanitation.

The ordinance and code of the PHS is so worded that it may be used with or without grading provisions. Under the grading plan a restaurant is required to display a sign showing an A, B, or C rating from a local health department on the basis of PHS standards. If the nongrading type of ordinance is used a restaurant is required to meet the grade A provisions or lose its license.

The ordinance has been adopted as a regulation by 29 states and the District of Columbia, and on a local basis by 212 counties and 529 municipalities in 43 states and the Territory of Alaska.

JOINT BOARD OF DIRECTORS OF THE OREGON SNA, SLNE, AND SOPHN

In Oregon the first steps in the organization of the Joint Board of Directors of the three state nursing organizations—the Oregon SNA, SLNE, and SOPHN—were completed on February 9, 1951. Earlier meetings at which Mrs. Jean Hamilton, president of the OSNA, served as temporary chairman, had seen the outlining of areas of common interest or overlapping authority and the appointment of a Committee on Nominations.

At the February meeting Mrs. Hamilton relinquished the temporary chairmanship to the elected officers. The president of the OLNE became the chairman; a lay member of the OSOPHN vice-chairman; and an elected director of the OSNA, secretary. The executive secretary of OSNA functions as administrator.

A Steering Committee of six is composed of the three elected officers and the presidents or vice-presidents of the three parent organizations. The committee has been instructed to organize a joint committee for the improve-

ment of nursing service to take responsibility for popular institutes within the state and to continue the study of Oregon's nursing resources.

All joint committees will be built around existing committees. The Steering Committee will work with already functioning committee groups in developing programs and plans.

STATE DIRECTORS' MEETING

State directors of public health nursing from forty-four states, the District of Columbia, Puerto Rico, and Alaska met in Washington, March 12-16 for their biennial conference with the Children's Bureau and the Public Health Service, Federal Security Agency. The subject of personnel for the emergency period received considerable attention. In her talk on the utilization of nursepower Ruth Freeman, nursing consultant, National Security Resources Board, estimated the country should have 63,000 more nurses now and another 35,000 by 1960. She pointed out that of the 205,000 inactive nurses at present, 87 percent are married, 57 percent have dependents under the age of eighteen, and about 10 percent are over the age of fifty. It is unrealistic to count on these nurses to fill unmet needs.

Katharine Lenroot, chief of the Children's Bureau, stated that nurses should consider themselves the community's eyes and ears regarding civil defense and other emergency problems. She hoped the United States would do a better job in day care programs than was done during World War II. Anna Fillmore, general director, NOPHN, participated in the several sessions as a resource person.

The state directors were particularly concerned with the preparation of public health nurses. They agreed that more field training opportunities must be developed.

ANA APPOINTMENT

Jean Thurston has been appointed assistant executive secretary in charge of public relations for the ANA. She replaces Annie Laurie Crawford, who has accepted a position with the Minnesota Mental Health Commission.

Prior to joining the ANA Miss Thurston was a public relations executive with the firm of Edward Gottlieb & Associates in New York, and earlier assistant director of public information for Wilson College, Chambersburg, Pennsylvania.

Mrs. Judith Whitaker, who has been serving as assistant executive secretary on public relations for ANA on a parttime basis, will continue in this position.

● The School of Nursing Education, Catholic University of America, announces a workshop on the organization of hospital nursing services, to be held June 12-22. It is designed for nurse administrators responsible for the development of hospital nursing services, supervisors and head nurses in the various clinical fields, and nurse educators.

The program will include the determination of nursing functions, organization of personnel for democratic functioning, concepts of interpersonal relations, and the relationship between nursing service and nursing education.

● An institute for workers with the tuberculous will be conducted at Chapel Hill, North Carolina, August 12-17, under the sponsorship of the North Carolina Tuberculosis Association and the University of North Carolina School of Social Work. Similar to last summer's institute held under the same auspices, it is designed for people who work with the tuberculous, whether in an administrative or supervisory capacity or in direct service.

Lecture subjects will be the patient as a whole; the patient in relation to his illness, his family and other important persons, and his work; and a historical background of the treatment of tuberculosis. Participants will be divided into small groups to discuss lecture content and its implications for their work.

Tuition will be $12; rooms in dormitories $8 a week per person. Further information may be secured by writing Frank W. Webster, Executive Secretary, North Carolina Tuberculosis Association, Inc., 2620 Hillsboro Street, Raleigh, N. C.

● Two international summer schools on social services in Great Britain have been announced by Roffey Park Institute of Occupational Health and Social Medicine, Horsham, Sussex, England. The schools, to be held July 30-August 10 and August 13-24, are designed for doctors, social workers, personnel managers, vocational advisers, psychologists, and senior nursing administrators.

The program covers such topics as the social services in Britain, recent developments in vocational guidance, case demonstrations and conferences, the rehabilitative work of Roffey Park, and social services connected with hospitals. A variety of tours have been arranged, ranging from a visit to Heritage Crafts Schools and Hospitals to a tour of Oxford.

RAISE THE FLAGS—for 10 years of enrichment!

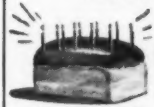
Yes, it was ten years ago this May that U.S. bakers and millers voluntarily started enriching white bread and flour—thus contributing immeasurably to the nation's well being. An eminent nutrition authority says:

> *"Enrichment of bread has meant not merely enriching the bread, but enriching the lives of many of our fellow citizens—enrichment of life measured in a greater zest for living and improved resistance to disease."*

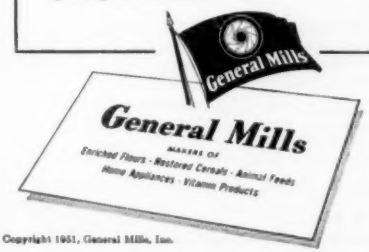
As part of a school-wide emphasis on nutrition, the children in the picture above have constructed a cardboard model of a slice of bread . . . and have made flags representing various nutritive elements found in this common food. Thiamine, riboflavin, niacin and iron—the enrichment ingredients added to flour by millers and bakers—become more than just "big words" as the class learns what these, along with the other nutritive elements in bread, contribute to their over-all daily diets. And another big step forward in the study of foods is made as the children learn that "enriched" on a loaf of bread, a sack of flour, a package of rolls means *more* essential vitamins and minerals!

If you'd like help in starting or expanding a nutrition project, suggestions for dramatizing any phase of nutrition work, write to: Education Section, Dept. of Public Services, General Mills, Minneapolis 1, Minn.

VITAL STATISTICS ON FLOUR ENRICHMENT



Before the enrichment program was started ten years ago, virtually none of the nation's white bread and flour output was enriched. Today about 87% of family flour and 80% of commercial bakers' bread and rolls have extra vitamins and minerals added. To date, 26 states with 56% of the total population have laws requiring enrichment.



Books

(Continued from page 306)

SOCIAL HYGIENE

VENEREAL DISEASE CONTROL IN THE USA. Report of WHO Syphilis Study Commission, technical report series No. 15. International Documents Service, Columbia University Press, 2960 Broadway, New York 27. 69 p. 45c. Covering the history of the venereal disease control program in the USA, research, professional prostitution, diagnostic and treatment facilities, application of the US venereal disease control methods in national and international programs, et cetera, with special reference to penicillin in early, prenatal, and infantile syphilis.

CHILD CARE

PARENTS OF THE ORTHOPEDICALLY HANDICAPPED CHILD. E. Louise Ware. Mental Hygiene Series No. 3, Association for the Aid of Crippled Children, 580 Fifth Avenue, New York 19. 1950. 21 p. 35c. Describes the problems of parents adjusting to a child with a physical limitation. Tells how some parents are able to overcome their feelings of guilt and frustration by constructive planning for the child's special needs for growth and development, and also contains many practical suggestions for activities and methods that may be used by the public health nurse in helping parents to accept handicapped children.

PSYCHOLOGY

PSYCHOLOGY, PRINCIPLES AND APPLICATIONS. Marian East Madigan. St. Louis, C. V. Mosby Company. 1950. 403 p. $4.25.

MEDICAL ECONOMICS

SANTA CLAUS, M.D. W. W. Bauer. Indianapolis, The Bobbs-Merrill Company. 1950. 266 p. $2.75.

SOCIAL WORK

TELLING THE WELFARE STORY. State Charities Aid Association, 105 East 22 Street, New York 10. 1950. 39 p. 50c. Prepared for volunteer welfare groups, suggesting simple basic publicity measures for use by busy people especially.

INTERNATIONAL SURVEY OF SOCIAL SECURITY. International Labor Office, Washington Branch, 1825 Jefferson Place, N.W., Washington 6, D. C. 1950. 236 p. $1.50.

GERIATRICS

PLANNING THE OLDER YEARS. Edited by Wilma Donahue and Clark Tibbits. University of Michigan Press, Ann Arbor, Michigan. 1950. 248 p. $2.50. Of special value to middle-aged and older persons who wish to learn about aging or want guidance in planning for their later years. Contains many new and useful concepts and evaluations of present practices.

POSITIONS AVAILABLE

Advertisements in this column are accepted at the following rates: 10c a word with a minimum of $3 for 30 words or less, MONEY TO ACCOMPANY ORDER FOR INSERTION. Agency members or sustaining members may have ONE insertion up to 50 words without charge. Closing date for copy and cancelation is the 1st of the month previous to publication.

WANTED—Physical therapist. Able to take charge of department. 170 bed hospital near Detroit. Maintenance available in nurses' home. Apply: Wyandotte General Hospital, Wyandotte, Michigan.

WANTED—Director, generalized nursing program; population 78,000; 13-nurse staff, one supervisor; preparation required: bachelors degree, 5 years of public health nursing experience, at least 2 of which must have been under adequate supervision and 2 of which involved supervision of public health nurses; New York State retirement plan; 2 days vacation a month, 1 day sick leave a month; car furnished for professional use. Apply to Dr. H. C. Miles, Cattaraugus County Health Department, Olean, New York.

WANTED—Public health nurses for county health departments in Oregon; salary $260 or more to start; established personnel policies; career opportunities. For detailed information write today to A. T. Johnson, Merit System Supervisor, 1019 S.W. Tenth, Portland 5, Oregon.

WANTED—Public health nurses, New York City Department of Health; immediate appointment on provisional basis; generalized service includes maternal and child care, school health and communicable disease control; starting salary $2,400; 37-hour week, liberal vacation and sick time allowance, pension rights, inservice training; applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, New York.

WANTED—Directing supervisor, public health. Visiting nurse work, school health program; salary based on experience; 40-hour week; 30 days vacation with pay; sick leave; small staff; mileage for own car. Requirements: college degree, postgraduate work in public health; staff nurse experience. Write to Northern Bergen Nursing Service, Inc., Ramsey, New Jersey.

WANTED—Supervisor for nonofficial agency in Philadelphia-Main Line area; generalized service including school health program; student affiliates; 13 field nurses and assistant supervisor; one month vacation, 39½-hour week, sick leave, retirement plan; allowance of 8c a mile for use of own car; preparation and experience which meet NOPHN standards required; salary open. State qualifications and date available. Apply to Executive Secretary, Community Health and Civic Association, 25 East Athens Avenue, Ardmore, Pennsylvania.

WANTED—Director, public health nursing service, also educational director, combined city, county, and VNA program; industrial city, population 80,000, county population 200,000; southeastern state; excellent salaries for experienced well prepared candidates. Write to box 5651, PUBLIC HEALTH NURSING magazine.

WANTED—General duty nurses. Single rooms available in nurses' residence at $15 a month; beginning salary $240 a month, $10 increase after two years; 40-hour week; $10 additional for 3-11 p.m. and 11 p.m.-7 a.m. shifts; operating room and delivery room nurses with one year of previous experience or special preparation, $10 additional; retirement plan and social security provided. Write to Director of Nurses, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

WANTED—Staff supervisor for visiting nurse organization; must meet NOPHN requirements; retirement plan; social security; 30 days vacation, 14 days sick leave; beginning salary dependent upon previous experience and training; semi-annual salary increases to maximum. Write to Director, Visiting Nurse Association, 316 Elizabeth Street, Utica, New York.

WANTED—Director, VNA, Muncie, Indiana; industrial city of 65,000, State Teachers College; NOPHN qualifications preferred; 5-nurse staff; student program; liberal personnel policies; car essential; salary open. Write to Mrs. Louis P. Fisher, RR2, Farmland, Indiana.

WANTED—Public health nurses for positions in urban and rural agencies, official and private, in various parts of the country. No fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57 Street, New York 19, N. Y.

WANTED—Staff nurses in official agency; generalized program, university community; salary based on education and experience; car essential, travel allowance. Write to Miss Grace Schroth, Supervising Nurse, Champaign-Urbana Public Health District, 505 South Fifth Street, Champaign, Illinois.

WANTED—Staff nurse and substitute for nonofficial agency in attractive industrial community, population 83,000; generalized program; 10-nurse staff; salary based on preparation; excellent personnel policies, 5-day week, 4 weeks paid vacation, retirement plan and social security. Apply to Director, Visiting Nurse Association, 194 Concord Street, Manchester, New Hampshire.

WANTED—The expanding National Blood Program of the American National Red Cross offers a different professional nursing specialty to nurses who can fill chief nurse and deputy nurse positions in blood centers. A college degree or at least two years of college work is required, as well as experience in teaching, administration, and public relations. Blood bank or operating room experience is desirable but not required. Inquiries should be directed to Mr. Raymond R. Fisher, Administrator for Personnel Services, National Headquarters, American National Red Cross, Washington, D. C., and reference should be made to the National Blood Program.

WANTED—Qualified staff nurses for combination agency, private and official; program includes bedside nursing, maternal and child care, communicable disease, parochial school nursing; good salary, depending upon preparation and experience; 5-day week, liberal vacation and sick leave, retirement. Write to Miriam A. Dailey, Director, Public Health Nursing Service, 65 Chestnut Street, Montclair, New Jersey.

WANTED—Public health nurses and supervisor in tuberculosis, Baltimore County Health Department; population 270,000; suburban, industrialized, and rural areas; county seat 8 miles from Baltimore; generalized service including progressive school program; 50 field nurses; one month vacation; 5-day, 35½-hour week; sick leave; retirement plan; allowance of 7c a mile for use of personal car. Supervisor: degree and special preparation in tuberculosis nursing required; beginning salary $4,000. Public health nurses: qualified, beginning salary $2,600-$2,700; junior nurse, beginning salary $2,400; trainee, beginning salary $2,300. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—Public health nurses, general rural program. Salary: public health nurses, $2,652-$3,336; graduate nurses as assistant PHNs, $2,340-$2,772; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Hazel Higbee, State Health Department, Richmond, Virginia.

WANTED—Public health nurses; generalized rural program; salary starting at $2,400; 38½-hour week, 2 weeks vacation, 2 weeks sick leave; travel allowance; retirement benefits. Write to Health Commissioner, Wayne County Health Department, Wooster, Ohio.

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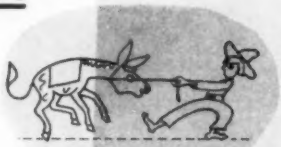

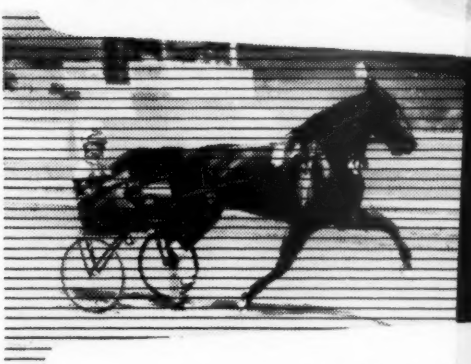

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1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512. 1949.

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